NHS
Wolverhampton
Clinical Commissioning Group

A meeting of the Wolverhampton Clinical Commissioning Group Governing Body

will take place on Tuesday 11th October 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 13 September 2016		1 - 8
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		9	Sustainability and Transformation Plan (STP)	Mr S Marshall	209 - 214
		10	Commissioning Committee	Dr J Morgans	215 - 222
		11	Quality and Safety Committee	Dr R Rajcholan	223 - 246
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		20	Minutes of the Primary Care Strategy Committee (previously called Primary Care Health Strategy Implementation Programme Board)		329 - 336
		21	Joint Negotiating and Consultation Committee		337 - 340
		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 8 November 2016 ~ Wolverhampton Clinical Commissioning Group Governing Body		

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Minutes of the Governing Body Meeting held on Tuesday 13 September 2016
Commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

VOTING MEMBERS ~

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

In Attendance ~

Ms K Garbutt	Administrative Officer
Mr M Hastings	Associate Director of Operations
Mr R Jervis	Public Health Director
Mr P McKenzie	Corporate Operations Manager

Dr D DeRosa introduced Mr Peter Price, Lay Member for Finance and Performance to the Governing Body.

Apologies for absence

Apologies were received from Dr R Rajcholan and Ms H Ryan.

Declarations of Interest

WCCG.1547 Dr D De Rosa reported there were no declarations of interest.

RESOLVED: That the above is noted

Patient Story

WCCG.1548 Ms P Roberts read out a patient story. The patient's battle to receive correct diagnosis and treatment for her condition commenced in 2007.

Minutes

WCCG.1549 RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group Governing Body meeting held on the 12 July 2016 be approved as a correct record.

Matters arising from the Minutes

WCCG.1550 There were no matters arising from the minutes.

RESOLVED: That the above is noted

Committee Action Points

WCCG.1551 RESOLVED: That the progress report against actions requested at previous Board meetings be noted ~

Minute 1465 – Emergency Preparedness, Resilience and Response (EPRR)

Dr De Rosa confirmed this is on today's agenda.

Minute 1519 – Better Care Fund Big Lottery

Mr S Marshall confirmed this action had been carried out.

Chief Officer update

WCCG.1552 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 pointed out that the The Wolverhampton Integrated Respiratory Lifestyle (TWIRL) project has been well attended and participants talk very positively about it. The pilot is

underpinned by a set of metrics to assess impact and outcomes and a report relating to this service will be brought to the Governing Body in the future.

Ms Curran pointed out item 2.8 relating to the award of "outstanding" for Wolverhampton CCG for 2015/16. A letter of congratulations has been received from Jeremy Hunt, Secretary of State for Health which has been shared will all staff. She added there are only 10 CCG's in the county with an outstanding award.

A System Leadership and Integration Event was held on 24 August 2016. Discussion took place around the over-arching principles to deliver the best possible health and care support to people in Wolverhampton.

The CCG has agreed to support a city-wide antimicrobial stewardship programme. The launch of this is on the 22 September 2016. The proposed scope will include all human healthcare and focus of shifting the behaviours of the public, patients, prescribers and staff.

Ms Curran briefed the Governing Body on the transition of System Resilience Groups into A&E Delivery Boards. NHS Improvement and NHS England wrote to all local systems across England in July 2016 setting out the key elements of the national A&E plan and a series of nationally mandated actions to be taken over the coming months to improve A&E performance.

RESOLVED: That the above is noted.

Emergency Preparedness, Resilience and Response (EPRR)

WCCG.1553 Mr M Hastings presented the report. He pointed out the table on page 3 of stating that there are no red indicators. The EPRR lead will be interviewing all Heads of Service to make assessments regarding how all systems are actioned. The CCG are also expected to review and report on the EPRR Core Standards returns of its main providers, Royal Wolverhampton Trust (RWT) and Black Country Partnership Foundation (BCPFT). Both providers have submitted their returns. Ms Roberts raised a concern regarding how GP practices and Vocare Limited are assessed. Mr Hastings stated this is the responsibility of individual organisations and is also contained within their contracts.

Mr Hastings stated we should be fully compliant by the end of January 2017. Mr J Oatridge stated that the Audit and Governance Committee had expressed concern around the business continuity not making progress which they felt was a major risk. A discussion took place regarding progress reports. It was agreed that a progress report is

submitted before Christmas and a full report in February 2017 to give assurance that all work is being carried out.

The Governing Body approved the progress of the EPRR.

RESOLVED: That a progress report is submitted before Christmas and a full report in February 2017.

Primary Care Full Delegation

WCCG.1554 Mr P McKenzie presented the report which was to ask the Governing Body to note the steps that will be required for the CCG to make an application for full delegation of Primary Care in line with the intention set out in the Primary Care Strategy. He highlighted the other constitutional changes contained within the report. Ms Roberts enquired when the next members meeting would take place. Mr McKenzie confirmed this will be on the 19 October 2016.

Mr McKenzie confirmed that the Governing Body will receive regular updates.

RESOLVED: That the above is noted.

Commissioning Committee

WCCG.1555 Dr Morgans presented the summaries for the reporting period July and August 2016. He highlighted concerns relating to Vocare Limited. The final draft contract was submitted to Vocare and resubmitted on the 12 August 2016 and is awaiting signature. Ms Roberts expressed concerns regarding Vocare that we are not identifying them as a risk. Mr S Marshall confirmed Vocare are delivering the service there is no risk for non-delivery even though the contract has not been signed A discussion took place regarding concerns relating to the contract not being signed. Ms T Curran stated that the risk of Vocare pulling out of the contract is very low.

Dr D Bush asked who monitors the monies relating to the Sustainability and Transformation Fund (STF). Ms C Skidmore confirmed that the contract is managed by the CCG and STF funding is a national initiative

RESOLVED: That the above is noted.

Quality and Safety Committee

WCCG.1556 Ms M Garcha referred to the report which provides assurance on quality and safety of care, and any exception reports that the Governing Body should be sighted on. She gave an update on the key issues of concern.

Dr De Rosa asked what the communication is regarding mortality. Ms Garcha confirmed that once a report is submitted to the Care Quality Commission (CQC) they report the information to the CCG. Ms Curran pointed out that the review process at the Trust is extremely robust and there are good examples on page 13 of the report.

Ms Garcha pointed out that we are waiting to hear when an Ofsted review will take place. The last one was carried out in 2011. There is a mock process in place and action plans are being actioned. Mr P Price referred to Serious Incidents at RWT and how they compare with other trusts. Ms Garcha stated there is a national learning system which can be accessed adding that RWT are open and report all incidents.

RESOLVED: That the above is noted.

Finance and Performance Committee

WCCG.1557 Ms Skidmore gave a brief outline of the Finance and Performance Committee reports. The finance performance reporting for month 4 meets all our financial targets for the year. She highlighted risk are becoming more apparent and the key areas which have driven these risks are ~

- National price of nursing care which is due to be reviewed in January 2017. This has caused a million pounds of cost pressure which is also nationally.
- Over performance in our acute contracts in the areas of non-elective activity and A&E.
- Quality, Innovation, Productivity and Prevention (QIPP) which puts pressure into the system. This will be reported on in month 5 what our risks are.

Mr Oatridge expressed concern relating to NHS Property Services relating to clear information regarding property values and rents. Ms Curran stated this is a national issue and work is currently taking place regarding inserting estate information on to a new piece of software which should be helpful.

Ms Skidmore referred to the Performance Indicators within the report which now give a full list. Dr De Rosa suggested this should include

trends on quality which would be useful. Ms Skidmore confirmed this could be added.

Ms Skidmore pointed out that there has been a national mandate to bring forward the contract timetable for this year. The contracts will be required to be signed in the current calendar year (23 December 2016).

RESOLVED: That the above is noted.

Audit and Governance Committee

WCCG.1558 Mr Oatridge gave an overview of the Audit and Governance Committee summary. He referred to the review of Performance against the Whistleblowing Policy. The Audit and Governance Committee noted only minor amendments to the existing content.

RESOLVED: That the above is noted.

Remuneration Committee

WCCG.1559 Mr Oatridge provided an overview of the report.

RESOLVED: That the above is noted

Primary Care Joint Commissioning Committee

WCCG.1560 Ms Roberts gave an overview of the report which provides an update from the meetings of the Primary Care Joint Commissioning Committee which took place on the 5 July and 2 August 2016. Dr De Rosa raised a point relating to GPs working together in groups and sharing information this is a key issue and training will be delivered relating to this.

RESOLVED: That the above is noted.

Communication and Engagement update

WCCG.1561 Ms Roberts presented the report which updates the Governing Body on the key communications and participation activities. She highlighted the Practice Managers Forum which discussed a variety of topics in July. She added that RWT are working to change the culture around complaints.

RESOLVED: That the above is noted.

Minutes of the Quality and Safety Committee

WCCG.1562 RESOLVED: That the minutes are noted

Minutes of the Commissioning Committee

WCCG.1563 RESOLVED: That the minutes are noted.

Minutes of the Finance and Performance Committee

WCCG.1564 RESOLVED: That the minutes are noted.

Minutes of the Audit and Governance Committee

WCCG.1565 RESOLVED: That the minutes are noted.

Minutes of the Primary Care Joint Commissioning Committee

WCCG.1566 RESOLVED: That the minutes are noted.

Minutes of the Health and Wellbeing Board

WCCG.1567 RESOLVED: That the minutes are noted

Any Other Business

WCCG.1568 Mr Marshall reported that Vocare Limited have agreed the contract.

RESOLVED: That the above is noted.

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

WCCG.1569 There were no questions from the public/press.

Date of Next Meeting

WCCG.1570 The Board noted that the next meeting was due to be held on **Tuesday 11 October 2016** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 2.50 pm

Chair..……………………………………..

Date ………………………………………

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Wolverhampton Clinical Commissioning Group Governing Body

11 October 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	
12.7.16	WCCG.1521	End of Life Strategy – The final report is brought back to the Governing Body	October 2016	Jeff Love/Steven Marshall	
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	

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NHS
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Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY MEETING

11 OCTOBER 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 • **Domain2:** Performance – delivery of commitments and improved outcomes • **Domain 3:** Financial Management • **Domain 4:** Planning (Long Term and Short Term) • **Domain 5:** Delegated Functions	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.

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 A meeting was held between the CCG and NHS England regarding the ETTF bids that were submitted. In summary the following points were covered:

2.1.2 The funding available is now £404m nationally, not the £750m originally stated. There has been no change to the Premises Cost Directions as yet, this was expected in September and we are now told this could be later this year.

- The maximum funding for ETTF improvement grant schemes will be 66% and maximum funding for ETTF new build schemes is to be confirmed (approx. 40% is currently being mentioned).
- Funding for Technology schemes will be 100%. The West Midlands has been awarded £33m to spend by March 2019, CCGs have been asked to identify what they can spend;
  - Before 31 March 2017 (known as Cohort 1)
  - Before 31 March 2019 (known as Cohorts 2 and 3).
- The £33m awarded to the West Midlands has been split with £8.3m identified for cohort 1 and £24.6m identified for cohorts 2 and 3.

2.1.3 A meeting with CCGs will take place on 26 September, this will be chaired by David Williams (NHSE) with John Harness (Regional ETTF lead) to discuss how the money will be spent and the bidding process - this will be handled on a Sustainability and Transformation Plan (STP) footprint. Some Technology schemes have been identified and had funding allocated to them, these were schemes rated as high priority by the individual CCGs and are deliverable in cohort 1. Wolverhampton is currently compiling an STP wide technology bid in line with the original submission for the City, along with two smaller estates bids that could potentially be completed by 31/03/2017. For Cohorts 2 & 3 the CCG will submit the larger estates projects. All of the projects in the original list will be progressed by the CCG and those not supported by the ETTF (of which this will be the vast majority, taking the funding available into consideration) will be put forward for alternative funding sources.

2.2 Healthy Living Pharmacies

2.2.1 There is a new programme of work nationally called Healthy Living Pharmacies which is being led by the Local Pharmaceutical Committee (LPC) in Wolverhampton. It will encompass treating minor ailments in pharmacy but also enabling prescribing out of hours, thus stopping patients going to Walk in Centres or A&E just for prescriptions. Updates will be forthcoming as the CCG and LPC work together on this project.

2.3 National Diabetes Prevention Programme

2.3.1 The NHS Diabetes Prevention Programme (NHS DPP) is a joint commitment from NHS England, Public Health England and Diabetes UK, to deliver at scale, evidence based behavioural interventions for individuals identified as being at high risk of developing Type 2 diabetes. Wolverhampton and Walsall CCG's are working together to put in an expression of interest to be included in the programme. Again, updates will be forthcoming as the project progresses.

2.4 Junior Doctor's Industrial Action

2.4.1 The CCG is working with Emergency Planning staff at the Trust to ensure all plans are in place and uploaded to national teams in readiness for the forthcoming planned industrial action. More details will emerge in the press over the coming days and weeks but we are assured as a commissioner that the main provider has mitigating plans in place for this action.

2.5 e-RS System within the Quality Premium

2.5.1 One of the Quality Premium targets for this year is an increase in the use of the e-RS system (previously known as Choose and Book). The CCG is working with the Trust to review the current processes with a view to increasing utilisation by at least the minimum requirement of 20% in order to achieve the maximum financial, which could then be re-invested into GP practices. Progress on this will be discussed with member practices.

2.6 New Models of Care

2.6.1 The CCG continues to work with colleagues on new care models around primary care in line with the Primary Care Strategy ratified by member practices. This collaborative work will enable the CCG to look at the changing outcomes from the practices involved in the new way of working to identify what works well and what does not. The ultimate aim is to implement best practice and share this with other practices across the CCG. Progress is monitored via the CCG Primary Care Strategy Committee which will in turn provide reports to the Governing Body.

2.6.2 Primary Care Home (PCH)

- The CCG Primary Care Team continue to work collaboratively with the PCH groups of practices, looking at new delivery models for services and identifying potential areas for efficiencies within practices so that money can be re-invested to improve patient outcomes. Key metrics are being developed to measure impact.

2.6.1 Vertical Integration with RWT (VI)

- The CCG's Performance Team are currently working with The Royal Wolverhampton Trust (RWT) to finalise the key performance indicators for the Vertically Integrated practices. Where possible the same key metrics will be used as for the PCH model to support our commissioning strategies going forward.

2.7 BCF Programme Board

2.7.1 A meeting of the BCF Programme Board took place on 8 September 2016, the focus of the discussions were around progress on rationalising estates to co-locate health and social care staff. Due to the wider estates agenda being across the four organisations, and regionally across the Black Country, it was agreed that BCF should have representation on the Local Estates Forum. Site visits have been undertaken across the three localities to determine whether any existing estates can be utilised whilst the CCG await the outcome of the Estates and Technology Transformation Fund bids.

2.7.2 To support the move towards integrated working, discussions took place around the short-term solution of a shared care record (Fibonacci) which is set to go live in December 2016. The focus will now shift towards ensuring any future IT related developments are part of the Local Digital Roadmap.

2.8 System Leadership and Integration – Transition Board

2.8.1 A planning meeting for the forthcoming schedule of Wolverhampton Transition Board meetings took place on 8 September 2016. As reported last month, the purpose of creating such a board is to ensure system leaders combine efforts to benefit people living in Wolverhampton.

2.8.2 The organisations involved are Wolverhampton CCG, Royal Wolverhampton NHS Trust, Black Country Partnership NHS Foundation Trust and the City of Wolverhampton Council. The Transition Board will be made up of executive leads from each organisation and will act as a joint forum to support system transformation across Wolverhampton whilst not ceding any organisational sovereignty.

2.9 A & E Delivery Board

2.9.1 In line with the national guidance, a robust process was followed which resulted Wolverhampton System Resilience Group successfully transitioning to an A&E Delivery Board from 1 September 2016.

2.9.2 The first meeting of the AE Delivery Board was held on 14 September 2016, and subsequent meetings will be held monthly.

2.9.3 The national guidance outlines key mandated areas which the A&E Delivery Board will be responsible for. An A&E Operational Group has been established to support the Board with wider membership from across the health and social care economy including the voluntary sector and neighbouring CCGs.

2.10 Black Country Sustainability and Transformation Plan

2.10.1 A meeting of the Black Country STP Sponsorship Group took place on 16 September 2016; items discussed included finance, efficiency, and place based care across a number of work streams, workforce and infrastructure. A further iteration of the plan has been produced for submission to NHSE. No organisation within the STP footprint has 'signed off' the plan given the embargo on taking this to any public board, the plan therefore remains a draft document.

2.11 NHS 111

2.11.1 Mobilisation of the new provider remains on track. There remain on-going communication challenges between outgoing and incoming providers. The current live service is experiencing operational issues due to staff morale, sickness and attrition, however these are being managed and risks mitigated.

2.11.2 The 'go live' date is still on track for 8 November 2016 followed by a 48 hour transition and operationalisation window with full delivery of the specified service from 10 November 2016. CCG Accountable Officers will meet on 10 October 2016 to make a final decision about 'go' or 'no go'.

2.12 Wolverhampton Health Scrutiny Panel

2.12.1 I was asked to attend the health scrutiny panel meeting on the 15 September to provide a briefing about the CCG, what we do, what are our priorities, what are our risks. The meeting went well and councillors appreciated the information and discussion. Attached as appendix 1 are the slides I shared with the panel.

Trisha Curran
Interim Chief Officer
Date: 22 September 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)	**Trisha Curran**	**22/09/16**

APPENDIX 1

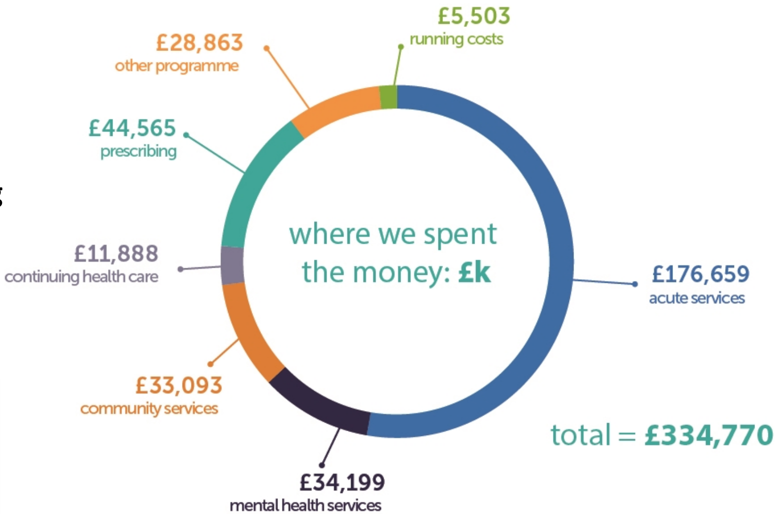
WOLVERHAMPTON CCG

We are responsible for ***commissioning* (buying) health services** to meet the health needs of the local population.

In addition, **we monitor, evaluate and manag the performance of those services**, ensuring they are safe and clinically/cost effective.

The CCG in numbers

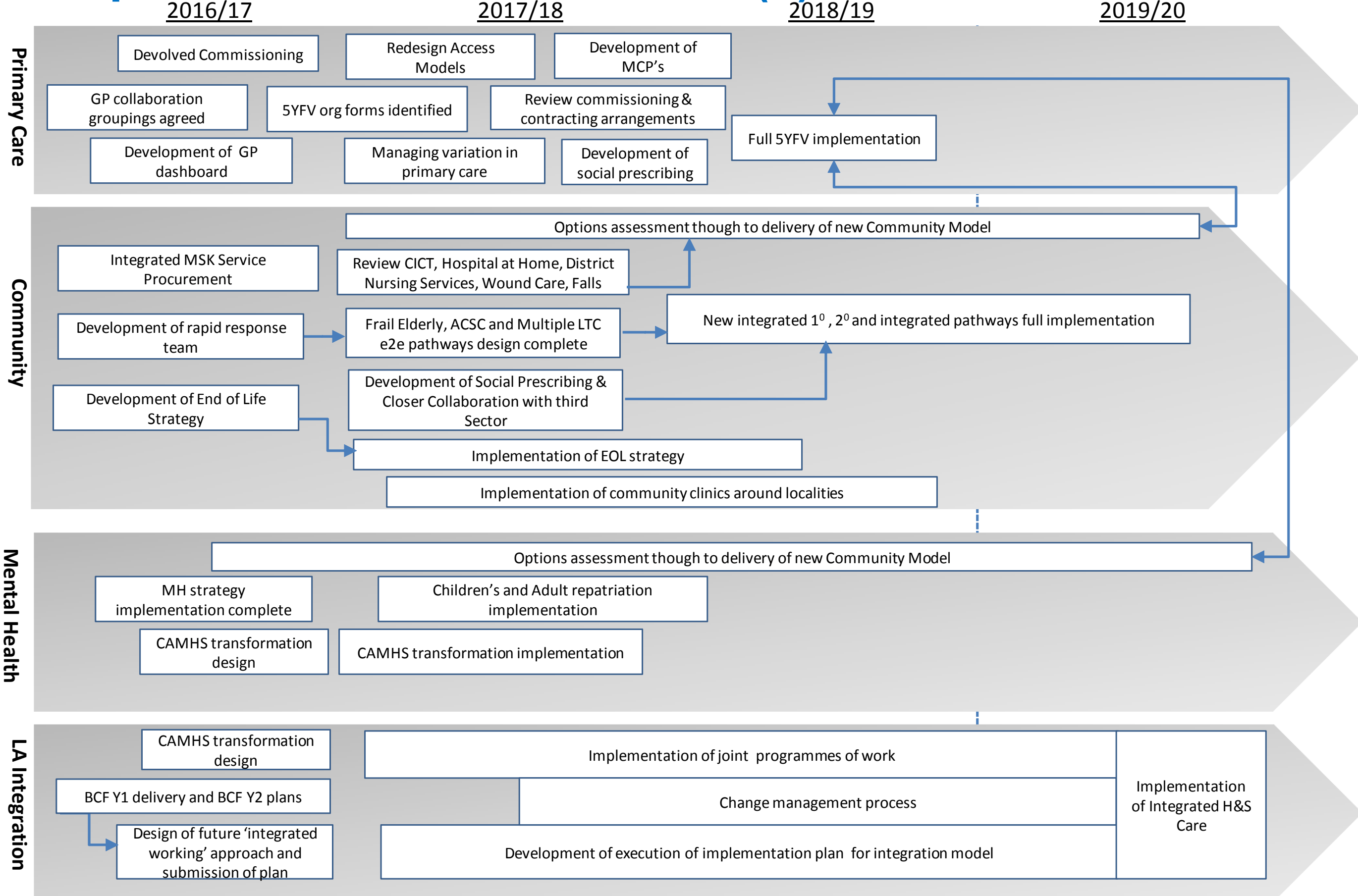
46	GP practices
£341m	Annual budget
Ca. 250,000	Registered patients



Our budget for the year was £341.742m. This included money to run the CCG, which came to £5.5m.

We commission :
- ✓ Hospital services
- ✓ Mental health services
- ✓ Community services
- ✓ Primary Care (jointly with NHSE)

We don't commission:
- × Pharmacists
- × Dentists
- × Specialist services (e.g. heart and lung transplants)
- × Public health (e.g. screening, family planning, drug and alcohol support



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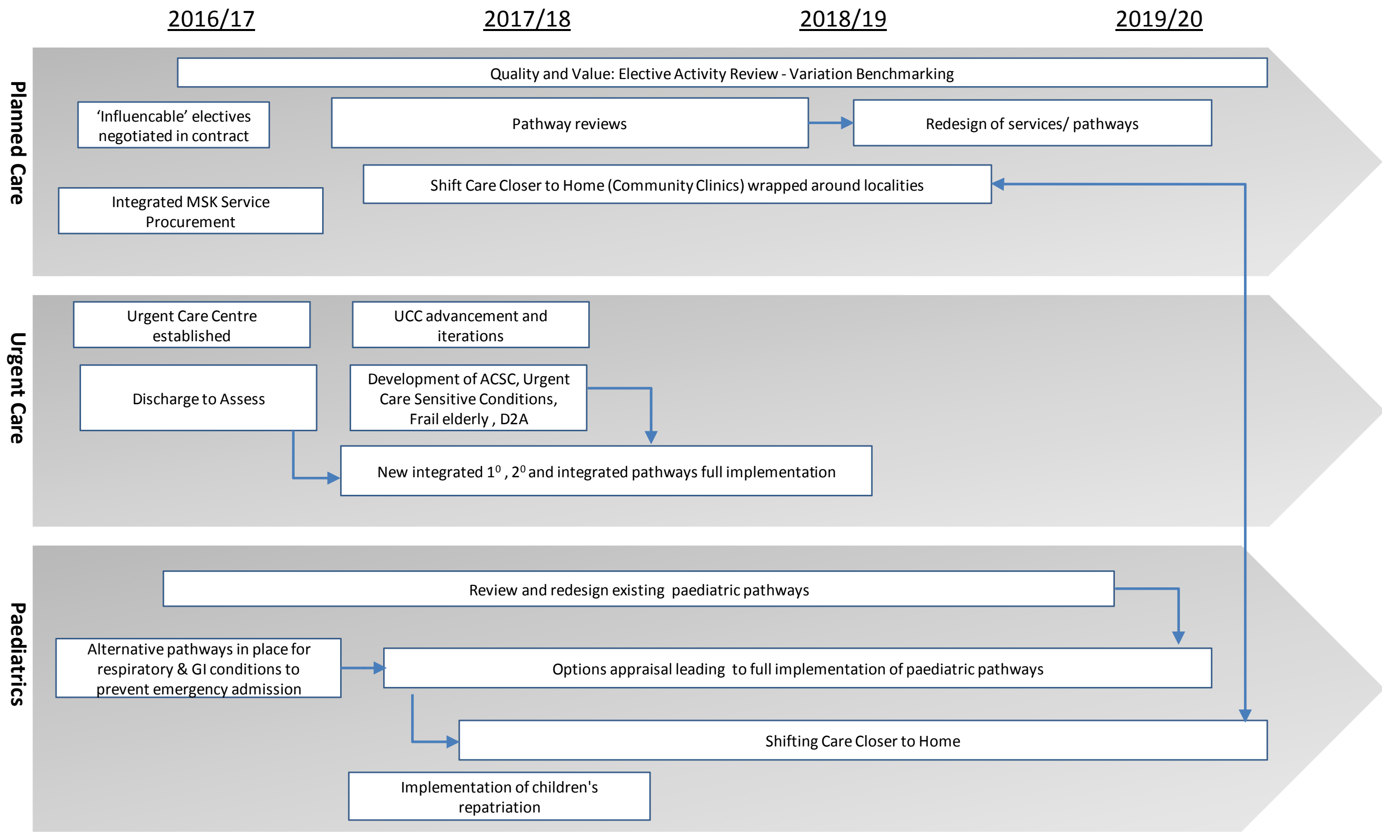
Wolverhampton Clinical Commissioning Group



NHS
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Key Challenges

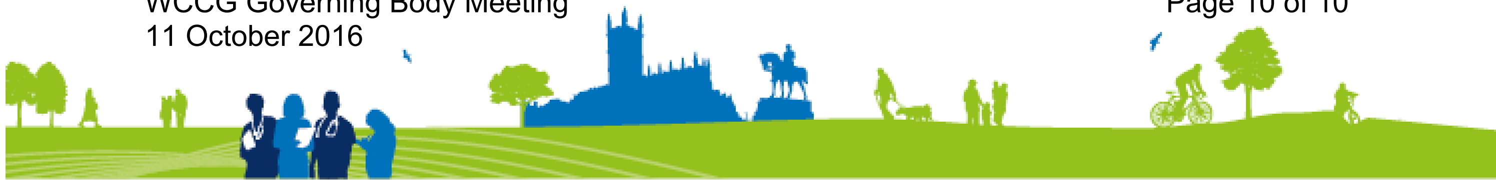
1. Financial…!

2. CHD/COPD/Multiple LTC/Frail Elderly/Mental health

3. Rising tide of A&E attendances

4. Black Country plan and balancing with the priorities of Wolverhampton…resources

5. Change to the Primary Care Model



NHS
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WOLVERHAMPTON CCG

GOVERNING BODY 22nd OCTOBER 2016

Agenda item 7

Title of Report:	**End of Life/Palliative Care Strategy**
Report of:	Karen Evans
Contact:	Karen Evans
Integrated Care Programme Board Action Required:	☒ **Decision** ☐ **Assurance**
Purpose of Report:	To ask the Governing body to approve the Wolverhampton End of Life care Strategy.
Public or Private:	Public
Relevance to CCG Priority:	
Relevance to Board Assurance Framework (BAF):	
• **Domain 2a:** Performance – delivery of commitments and improved outcomes	The strategy ensures the delivery of key components of end of life / palliative care across the whole pathway, ensuring a focus on person centred coordinated care.
• **Domain 2b:** Quality (Improved Outcomes)	This strategy will include a robust outcomes framework that focuses on 4 domains, improving patient/carer experience, clinical effectiveness, integrated care and holistic care planning.
• **Domain 3:** Financial Management	This strategy is aiming to improve the cost effectiveness and efficiency of EoL care across the whole health and care economy through development of an integrated, responsive care pathway
• **Domain 4:** Planning (Long Term and Short Term)	This strategy will ensure the development of an integrated End of Life care pathway co designed by all partners. In the short term we will pilot and embed Advance

	Care Planning to ensure the delivery of integrated, person centred care and in the long term develop and embed an electronic shared care record across all providers of care to support care coordination.

1. BACKGROUND AND CURRENT SITUATION

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

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

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

1.4 Children transitioning into adult services are also covered in the strategy. Providers need to ensure that children and their families are supported and enabled to undertake a smooth transition from children's to adult's services.

2. MAIN BODY OF REPORT

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

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

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

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

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

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

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

2.5. The Strategy also recommends the earliest possible implementation of Advance Care Planning for end of life care for people with life-limiting long term conditions and a document will be piloted this year with a view to fully roll this out by April next year.

2.6. The model proposed for end of life care in Wolverhampton places the person and those closest to them, firmly in the centre.

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

3. CLINICAL VIEW

3.1. Clinical input and guidance into the strategy is being provided through the Steering Group chaired by Dr Manny Samra, a local Macmillan GP Facilitator. The Steering Group also includes a range of clinicians and health and care professionals from partner agencies involved in the provision of End of Life care including Consultants in Palliative medicine.

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

4. PATIENT AND PUBLIC VIEW

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

4.2. The patients voice is also being represented by a member of Healthwatch

RISKS AND IMPLICATIONS

Key Risks

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

Financial and Resource Implications

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

Quality and Safety Implications

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

4.6. A full quality impact assessment has been undertaken.

Equality Implications

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

Medicines Management Implications

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

4.9. The Strategy includes the requirement for anticipatory medication to be available in a timely manner for those approaching the end of their lives to provide optimum symptom control.

Legal and Policy Implications

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

5. RECOMMENDATIONS

- **Receive** and **discuss** this report.
- **Approve** the End of Life care Strategy and timeline.

[2] A Different Ending – Addressing Inequalities in End of Life Care – Care Quality Commission, May 2016

[3] Hiding Who I am – The Reality of End of Life Care for LGBT People, Marie Curie, June 2016

Karen Evans
Solutions & Development Manager
Date: 13th September 2016

ATTACHED: Wolverhampton End of Life care Strategy, population profile and timeline.

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	Date
Clinical View	**Dr Manny Samra**	
Public/ Patient View	**Lesley Fellows/ Tracy Cresswell (Healthwatch)**	
Finance Implications discussed with Finance Team	**Not applicable at this point**	
Quality Implications discussed with Quality and Risk Team	**Molly Henriques-Dillon QIA submitted August 2016**	
Medicines Management Implications discussed with Medicines Management team	**David Birch**	
Equality Implications discussed with CSU Equality and Inclusion Service	**Submitted in August 2016**	
Information Governance implications discussed with IG Support Officer	**PIA submitted August 2016**	
Legal/ Policy implications discussed with Corporate Operations Manager	**Not applicable at this point**	
Signed off by Report Owner (Must be completed)	**Karen Evans**	**13.09.16**

Wolverhampton Integrated End of Life Care Strategy implementation plan

Is a working document which provides practical solutions to support delivery of this strategy's key recommendations; it has been developed in collaboration with our clinical advisory group and is based on learning and best practice.

** Indicates an area where a small amount of investment upfront will deliver a quick and effective result or 'quick win'

Recommendation	Action/Statement of intent	
Promoting earlier identification of patients approaching the end of life in Primary Care to support earlier advance care planning and enable choice	Programme of Primary Care education and support • GP education to include CCG supported events (Team W), RCGP events, Macmillan GPF practice visits	**
Raising awareness of EoLc and the management of this patient cohort in the Community	Raising the awareness of District Nurses to include • Initial induction • Mandatory training • Clinical teaching • Clinical reflection • Peer support	**
Raising awareness of EoLc and the management of this patient cohort in an acute setting	Programme of Secondary Care education and support including • that related to the Swan project and the rapid discharge home to die programme • Multi-disciplinary working that empowers nursing staff and allied healthcare professionals to identify patients and ensure their inclusion on EoL registers.	
Raising awareness and the management of this patient cohort in care homes	Raising awareness to include • Development of Nursing Home minimum standard • Promotion of and education related to the Integrated Care Model, ACP, Symptom Control	**
Promoting choice for all patients regarding EOLC and reducing unnecessary hospital admissions	• Education, awareness raising and debate in both Primary and Secondary care settings as above around the meaning and potential of Palliative Care. • Promotion and education related to the Advance Care Planning document • Education and Training programmes across the pathway relating	**

	to having difficult and sensitive conversations • Development of the holistic assessment to include physical, psychological, spiritual / cultural and social needs of patients and carers	
Ensuring patients and carers have the resources and information that they require to cope with and manage their EOLC needs	• Development of the care coordinator role • Undertake capacity & demand work in Primary and Community care (Community care links to ACC work stream Better Care Fund). • Development of a local Service Directory, (links to BCF and WIN) • Development of contact hub protected phone line for EOLC patients, their carers and professionals, 24/7, manned by qualified professionals who are able to signpost to services routinely and in the crisis situation. • Development of the third sector workforce to provide increased practical support in the home, extra support around the time of discharge from hospice or hospital, and if possible in a crisis situation. • Ensure services are responsive across the whole pathway, including equipment provision, and home oxygen • 24/7 District Nursing service across Wolverhampton • 24/7 Specialist Palliative advice available, with clear instructions around access • Development of clear processes for anticipatory prescribing • Development of a universal DNACPR policy and document that applies across the whole pathway	** **
Providing coordinated and integrated services across the whole pathway that are available to support people, including those in crisis 24/7	• Introduction of a handheld Advance Care Planning Document, with education delivered across settings • 24/7 District Nursing service across Wolverhampton • Further development and implementation of the Electronic Palliative Care Record • 24/7 Specialist Palliative Care advice available, with clear instructions around access • Development of clear processes for Anticipatory Prescribing • Development of a universal DNACPR policy and document that	** **

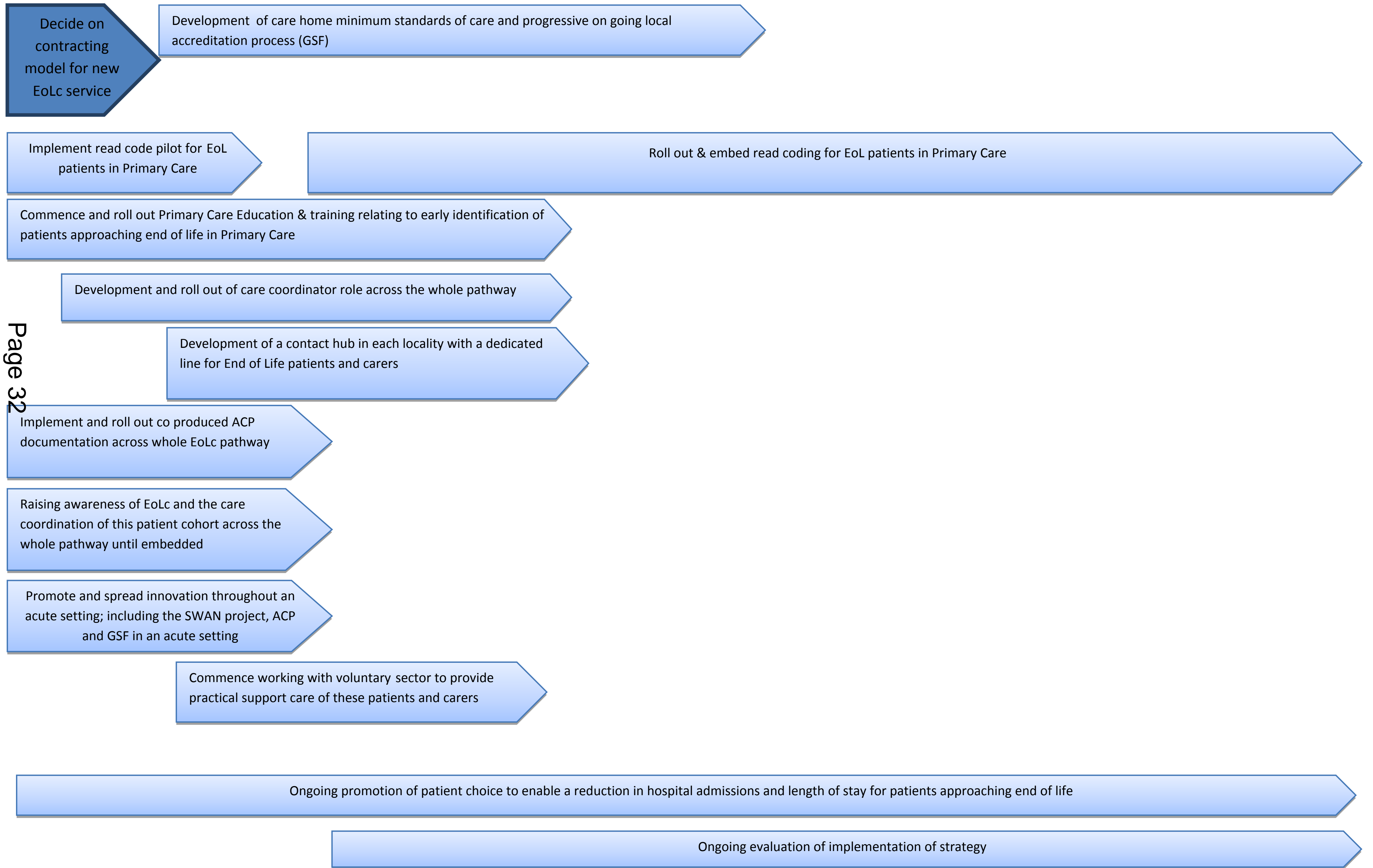
	applicable across the whole pathway	
Facilitation of discharge from the acute setting	• Continued promotion of rapid discharge home to die programme • Responsive services to support discharge including equipment and home oxygen • Responsive Community based services able to support the discharge of this cohort of patients	
The development and promotion of an integrated EOLc model that is universally recognised across the whole pathway and adopted by all agencies involved in the provision of care to those approaching the end of life	• On going development of the community integrated service model to include all settings (Linked to BCF). • Education and promotion of this model across all organisations and settings	**
Development of a knowledgeable and competent workforce that is trained in all aspects of EOLc as appropriate to their role and setting	• Education and training needs assessments across settings – secondary and primary / community care • Engagement with local specialist palliative care providers of education to deliver relevant, tailor-made training packages which will address the needs identified in both secondary and primary / community care. • Acknowledgement of the need for place based learning, peer review and peer support, and an option to explore external facilitation of training & support • Develop links to HEE and explore options for support in educational sessions	**
Specific consideration of EOLc needs of the residents of care homes, and their professional carers	• Development of Nursing Home minimum standard and local accreditation process • Education and Training – (Link to the PROSPER project) • Equipment (syringe drivers) training and practical support at times of need (e.g train the trainer sessions) • Implementation and adoption of standardised, whole pathway paperwork and IT solutions	** **
Specific consideration of the EOLc needs of under-represented groups	• Recruitment of Clinical Champions for each of the under represented groups to ensure that recommendations may be developed and implemented. • The recommendations and implementation plan of this strategy apply to each of the groups detailed within the glossary within the EoLc Strategy.	

	• Improve ethnic monitoring, include White groups and religions and provide data locally • Involve minority ethnic groups in service user events when planning future policy strategies to improve EOLc and create public awareness campaigns • Include information about available palliative care services for BAME communities in the local directory of services (WIN)	
Children transitioning into adult services	• Promotion of early identification of young people with Palliative Care needs who are approaching transition within primary care and across all settings • Promotion of integration of care across settings for young people. • Development of the care coordinator role for this group • Engagement with paediatric and adult local providers addressing these issues, and with the recently established 'Transition Taskforce' (2012-2015) commissioned by Together for Short Lives.	
Development of partnerships with third sector organisations and local communities to support innovation, particularly around supporting patients and carers in the home environment, and incorporating their spiritual and cultural needs in to their care	• Development of the voluntary sector and the local volunteer workforce to provide increased practical support in the home, extra support around the time of discharge from hospice or hospital, and if possible in a crisis situation. • Engagement with local communities and projects	
Development of the IT support systems necessary to allow electronic co-ordination of patient information ensuring alignment with all agencies providing EoLc	• Further development and roll out of *'EPaCC'* system currently under development by RWT OR • Alternative option to be explored and costed • Development to ensure that local systems are aligned to enable an integrated care record	** **
Improved Bereavement care for family and carers	• People affected by bereavement should be offered appropriate support at the time of death that is culturally and spiritually appropriate, pre-bereavement, immediately and shortly afterwards and in the longer-term if necessary (to align with the	**

	wishes of the bereaved). • The development of a local model of bereavement is recommended, which could include but is not limited to: ➢ information about local support services ➢ practical support such as advice on arranging a funeral and support with cultural needs ➢ information on who to inform of a death, ➢ help with contacting other family members and information on what to do with equipment and medication ➢ general emotional and bereavement support, such as supportive conversations with generalist health and social care workers or ➢ support from the voluntary, community and faith sectors ➢ referral to more specialist support from trained bereavement counsellors or mental health workers	
On going CCG engagement with Service User and Stakeholder representatives to understand what local people want from local End of Life and Palliative care services	• Engagement with and recruitment of a range of patient champions who are currently experiencing services or carers whom have been impacted by services • Develop locality networks of patient champions to ensure a local focus on any current and future developments in End of Life and Palliative Care • Explore the opportunity for external support for this initiative (e.g Healthwatch, Macmillan)	
Defining and agreeing service outcomes, methods for the collection of baseline data, and plans for robust evaluation	• Development of robust service outcomes to support the delivery of person centred, integrated End of Life care services	

Implementation road map

2016			2017												2018											
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec



2016			2017												2018											
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec

Ensure equipment requirements of patients approaching the end of life are considered prior to procurement of service.

Ensure links are made with Equipment service following procurement to ensure responsive service for patients approaching end of life

Develop a continuous relationship with Health Education England to ensure all opportunities for education are captured and acted upon

Ongoing recruitment of patient/carer champions to ensure the patients voice is at the heart of all service redesign and enable co production

Ongoing proactive engagement with under represented groups to ensure services are fully inclusive

Develop Palliative Care and End of Life service entries on to the local directory of services (WIN)

Promote and support the development of processes to support the smoother transition into adult services for children with LLC's

Develop and roll out the care coordinator role for children transitioning to adult services

Further develop and roll out local EPaCC system across all professionals and all agencies delivering care and support to patients approaching end of life.

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NHS
Wolverhampton
Clinical Commissioning Group

Wolverhampton Integrated End of Life Care Strategy
2016 – 2020

The Royal Wolverhampton NHS Trust
City of Wolverhampton Council
We are Macmillan. Cancer Support
healthwatch Wolverhampton
Compton Hospice Caring Together

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1. Executive Summary

The aim of this strategy is to detail Wolverhampton's integrated approach to the design and delivery of a person centred, integrated, end to end End of Life care service.

We believe this strategy will deliver a flexible, responsive, quality service to those approaching the end of their lives.

It will provide reassurance that services will be wrapped around the patient at this difficult time and will facilitate person centred care encompassing the following elements:

- Early identification of the dying person to ensure patients are receiving appropriate care
- Advance care planning to facilitate the persons needs and wishes
- Coordinated care to ensure people don't fall through gaps
- Optimum symptom control based on clinical need
- Choice to support preferred place of care and death
- Workforce fit for purpose

Supporting this strategy will be a detailed outcomes framework that will include the requirement for providers to place equal importance on the improvement of patient/carer experience alongside key clinical indicators.

As Commissioners and providers we want to work collectively to make the care that surrounds dying, death and bereavement as good as possible, for all.

In line with the national vision for End of Life care, we aspire to ensure residents of Wolverhampton can say:

"I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)."[1]

The strategy recognises the need to ensure that everyone should have the right to high-quality palliative and end of life care when they have a terminal illness, regardless of their condition, where they live, or their personal circumstances and so is inclusive of all faiths, cultures and groups.

We recognise that the delivery of a truly integrated End of Life care service requires a significant cultural shift that sees a move from the commissioning and delivery of episodic care to a more responsive, person centred model that places the patient (and their loved ones) at the centre.

The strategy recognises that 'one size doesn't fit all' and that services need to flex and adapt as patients progress through each phase of their illness.

We intend to ensure our workforce is fit for purpose and that they work with patients and carers to 'make every moment count'.

[1] 'Every Moment Counts' National Voices,
National Council for Palliative Care and NHS England

2. Forward

"Care of the dying can be seen as an indicator of the quality of care provided for all sick and vulnerable people."[2]

It is an inevitable fact that everyone will die. The vast majority of us will also care for someone who is dying.

Death and dying are inevitable. Palliative and end of life care must be a priority. The quality and accessibility of this care will affect all of us and it must be made consistently better for all of us.

The needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities must be addressed, taking into account their priorities, preferences and wishes.

The provision of good quality End of Life care is essential if we are to fulfil our aspirations to enable everyone to have a good death.

It is difficult to achieve perfection for everybody every time. There can be a mismatch between what services can offer, what professionals hope to achieve and what the person, and their families, carers and those close to them seek or expect.

Palliative and end of life care requires collaboration and cooperation to create the improvements we all want.

Health and social care are equal partners in this endeavour. Cross-organisational collaboration is vital to design new ways of working that will enable each community to achieve these ends. These systems must reach out beyond the usual networks of organisations and communities to call upon contributions, ideas and actions from a wider spectrum of people. We need integrated health and social care systems that work with people, as well as for people.[3]

The Commissioners and Providers of Health and Care services in Wolverhampton are dedicated to achieving integrated care predicated upon what really matters to their patients and local communities. They see an absolute requirement for all providers to work together in a co-ordinated and coherent manner to provide the best end of life care for every person, irrespective of where, or how, they access the system and supporting them in achieving their preferred place of care.

We only have one chance to get it right.

The Government have recently issued their commitment to ensuring people receive good quality end of life care.[4]

They will ensure the delivery of their vision for personalised end of life care through the NHS Mandate and the CCG Improvement and assessment framework.[5]

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[2] Department of Health (2008) End of Life Care Strategy: Promoting high quality care for all adults at the end of life. London: The Stationery Office
[3] Ambitions for Palliative and End of Life Care, National Palliative and End of Life Care Partnership
[4] Our commitment to you for end of life care – DH July 2016
[5] NHS England 2016 CCG Improvement & Assessment Framework 2016/17

The Health & Social Care system is currently facing an unprecedented rise in demand whilst at the same time, it has little access to additional funding. Coupled with this, advances in medicine are resulting in a growing population of patients living longer with increasingly complex, chronic, life-limiting conditions.
Significant changes to how care is delivered to these patients is necessary, including the empowerment of patients to make informed choices about their care; working in partnership with them to deliver these choices.

The ambitions of Commissioners and Providers of Health and Social Care across Wolverhampton is to transform end of life care and ensure they are aligned with the "NHS Five Year Forward View", which sets out the strategic vision for NHS England, as the following extracts highlight:

"It is a future that empowers patients to take much more control over their own care and treatment... that dissolves the classic divide... between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment.... that no longer sees expertise locked into often out-dated buildings, with services fragmented, patients having to visit multiple professionals for multiple appointments, endlessly repeating their details.

Over the next five years and beyond, the NHS will increasingly need to dissolve these traditional boundaries….it requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care." [6]

The vision also states clearly that patients' own life goals are what count, that services need to support families, carers and communities, that promoting wellbeing and independence need to be the key outcomes of care, that patients, their families and carers are often 'experts by experience' and that Commissioners should learn much faster from the best examples, not just from within the UK but internationally.

National Voices have developed a narrative for person centred care for people near the end of their life – Every Moment Counts.[7]

The narrative details what person centred care means from the point of view of someone nearing the end of their life.

What is most important to them is:

"I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)."

For this reason, Commissioners and Providers across Wolverhampton have worked in partnership to develop this integrated strategy for End of Life care.

The successful implementation of the strategy will provide benefit most importantly for our patients and their carers, but also for the health and Social care professionals providing services, and for the local health economy.

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[6] NHSE Five Year Forward View October 2014
[7] Every Moment Counts – National Voice & National Council for Palliative Care
4 NHS England 2016 CCG Improvement & Assessment Framework 2016/17
5 NHSE Five Year Forward View October 2014
6 Every Moment Counts – National Voice & National Council for Palliative Care

This strategy is outcomes focussed with the dying persons needs based at the centre of those outcomes.

3. Acknowledgements

The development of this strategy has been supported and influenced by the following people and groups, who we would like to acknowledge for their encouragement, commitment, input and contribution:

- The Patients and Carers who attended the user engagement events and completed the online survey
- Local provider representatives who attended the stakeholder engagement events
- The project Strategic Group
- The project Operational Group
- Healthwatch
- Attendees of focus groups (Patients & Professionals)
- Respondents to the online survey
- Macmillan Cancer Support
- Local providers of End of Life care

3. Background

National Picture

The Palliative Care Funding Review commissioned research by King's College London and partners, estimates that between 92,000 and 142,500 people each year have an unmet need for palliative care.

People living with a life limiting illness and nearing the end of their lives have specific support needs which, if left unmet, can damage their quality of life. It is important that their needs for information, advice and support are addressed. These needs can include information about treatment, care options, psychological support, advice on financial assistance, support in self-managing their condition and planning for eventual death. Carers or those important to the patient also play a vital role in supporting people at the end of life.

- 1,539 people die in the UK every day
- 561,000 people die in the UK every year - Of these deaths 75% are not sudden, but expected
- 457,000 people a year need palliative care

The need for honest conversation and the importance of joined up care are as important for carers and families as individuals. The need for support from, and for, empathetic and competent health and care staff is as important for carers, families and those who are bereaved, as it is for the dying. As is the help that can be given by the communities of which we are part.

The Ambitions for Palliative and End of Life care published in September 2015 provides a framework for national and local health and care system leaders to take action to improve end of life care.[8]

We need to have a nation where each death matters. This means extending our concern beyond the care required by those living with predictable life shortening illness, to ensure a better response from the health and care system and from society, to sudden, unpredictable or very gradual dying.

[8] The Ambitions for Palliative and End of Life care September 2015

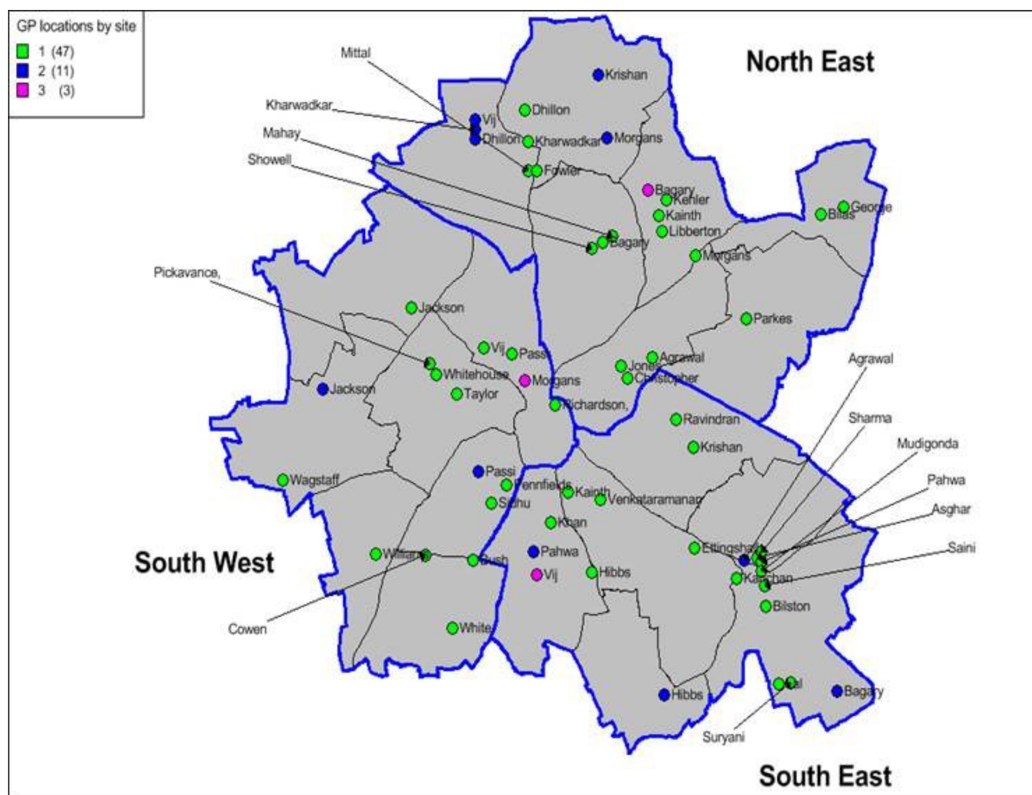
Current Situation

The City of Wolverhampton has approximately 2500 deaths per year.

Number of deaths in Wolverhampton 2004-2014 by age group -[9]

Age Band	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
<65	424	451	476	430	479	403	411	401	404	391	412
65-74	469	478	472	389	376	397	422	375	388	383	406
75-84	919	881	859	843	822	765	818	694	709	766	704
85+	709	759	767	825	803	805	804	852	873	920	909
TOTAL	**2521**	**2569**	**2574**	**2487**	**2480**	**2370**	**2455**	**2322**	**2374**	**2460**	**2431**

The City is diverse with an ever increasing population



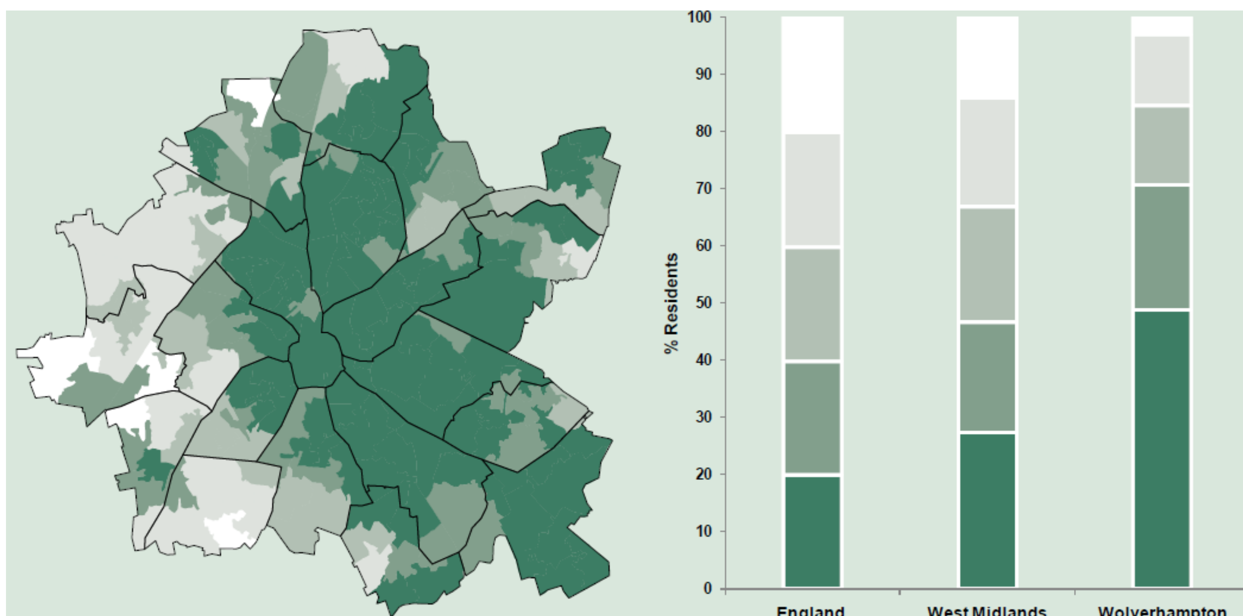
Based on Census 2011 data, the majority of residents in the city belong to the White ethnic group (64.5%), whilst the percentage of Black, Asian and Minority Ethnic (BAME) residents has risen since 2001 by 11% to 35.5%.

This Strategy recognises the requirement to commission and provide services that meet both the cultural and religious needs of our multi cultural population.

In 2007, 2 of Wolverhampton's 158 lower super output areas (LSOAs) fell into the top 1% most deprived in England

[9] Public Health England 2016

The figure below shows the deprivation level comparator between Wolverhampton, the West Midlands region and England, the darker the green, the more deprived, which shows Wolverhampton as a city area experiencing more than 2 x the level of most significant deprivation than the national average, and proportionately much lower areas of prosperity.



In recent years, new arrivals from European Accession countries have had an impact on the city's population.

People in Wolverhampton are living longer than ever before and the gap between life expectancy in the city and the national figure is closing. We know that socio-economic factors affect life expectancy.
In Wolverhampton and similarly disadvantaged communities, the determinants of health such as skills, jobs and housing, are well below the national average. There are six conditions which account for over half of the difference in life expectancy that exists between Wolverhampton and England.
These are heart disease, stroke, infant mortality, lung cancer, suicide and alcohol. This is seen disproportionally in the most disadvantaged communities.
Deaths due to alcohol and those occurring in infancy are the major reasons why life expectancy has not improved.[10]

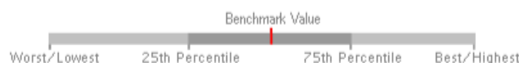
Over the 10 year period between 2004 and 2014 there have been some changes in where people in Wolverhampton end their lives. There has been a consistent decrease in the percentage of people dying in hospital and an increase in those dying at home or in a care home, but there are some years where those overall trends are much less pronounced.

- 6.6% fewer people died in hospital
- 3.7% more people died at home
- 2.6% more people died in a care home
- 0.7 % more people died in a hospice

[10] Wolverhampton In Profile Wolverhampton City Council

Place of Death[11]

Compared with benchmark: Better Similar Worse Lower Similar Higher Not Compared



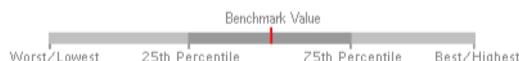
Indicator	Period	Wolves		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Hospital deaths, Persons, All Ages (%)	2014	1,344	55.3%	50.1%	47.4%	36.9%		67.4%
Hospital deaths, Persons, Aged 0 to 64 years (%)	2014	231	56.1%	48.2%	45.7%	32.1%		65.0%
Hospital deaths, Persons, Aged 65-74 (%)	2014	232	57.1%	51.5%	49.6%	36.3%		67.7%
Hospital deaths, Persons, Aged 75-84 (%)	2014	413	58.7%	53.4%	50.9%	39.7%		69.0%
Hospital deaths, Persons, Aged 85+ (%)	2014	468	51.5%	47.8%	44.4%	34.7%		67.6%
Home deaths, Persons, All Ages (%)	2014	540	22.2%	22.8%	23.0%	18.5%		29.7%
Home deaths, Persons, Aged 0 to 64 years (%)	2014	128	31.1%	33.4%	33.8%	22.5%		47.3%
Home deaths, Persons, Aged 65-74 (%)	2014	107	26.4%	29.3%	30.0%	19.8%		48.0%
Home deaths, Persons, Aged 75-84 (%)	2014	156	22.2%	23.1%	23.3%	14.9%		29.5%
Home deaths, Persons, Aged 85+ (%)	2014	149	16.4%	15.1%	15.5%	9.6%		26.4%
Care home deaths, Persons, All Ages (%)	2014	390	16.0%	19.4%	21.7%	5.8%		32.9%
Care home deaths, Persons, Aged 0 to 64 years (%)	2014	5	1.2%	2.4%	2.9%	0.0%		11.2%
Care home deaths, Persons, Aged 65-74 (%)	2014	26	6.4%	7.8%	8.1%	2.1%		19.7%
Care home deaths, Persons, Aged 75-84 (%)	2014	98	13.9%	16.6%	18.7%	6.5%		27.4%
Care home deaths, Persons, Aged 85+ (%)	2014	261	28.7%	34.0%	37.0%	11.6%		50.7%
Hospice deaths, Persons, All Ages (%)	2014	120	4.9%	5.6%	5.7%	0.1%		11.7%
Hospice deaths, Persons, Aged 0 to 64 years (%)	2014	27	6.6%	9.5%	10.4%	0.3%		21.8%
Hospice deaths, Persons, Aged 65-74 (%)	2014	35	8.6%	9.5%	10.2%	0.0%		25.0%
Hospice deaths, Persons, Aged 75-84 (%)	2014	31	4.4%	5.6%	5.7%	0.0%		14.0%
Hospice deaths, Persons, Aged 85+ (%)	2014	27	2.97%	2.17%	2.04%	0.00%		7.51%
Deaths in Other Places, Persons, All Ages (%)	2014	37	1.52%	2.06%	2.23%	0.99%		6.84%
Deaths in Other Places, Persons, Aged 0 to 64 years (%)	2014	21	5.1%	6.5%	7.2%	2.9%		14.3%
Deaths in Other Places, Persons aged 65-74 (%)	2014	6	1.5%	1.8%	2.0%	0.0%		9.9%
Deaths in Other Places, Persons, Aged 75-84 (%)	2014	6	0.85%	1.22%	1.36%	0.21%		5.65%
Deaths in Other Places, Persons, Aged 85+ (%)	2014	4	0.44%	0.93%	1.02%	0.00%		7.34%

Nationally, 86% of all hospital admissions in the last year of life are emergency hospital admissions with an average length of stay of 27 days accounting for 2.8million bed days.[12]

[11] Public Health End of Life care profiles 2014
[12] National end of life care intelligence network. What do we know now that we didn't know a year ago - 2013

Cause of Death[13]

Compared with benchmark: Better Similar Worse | Lower Similar Higher | Not Compared



Indicator	Period	Wolves		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Percentage of Deaths from Cancer, Persons, All Ages	2014	681	28.0%	29.0%	28.8%	24.6%		34.6%
Percentage of Deaths from Circulatory Disease, Persons, All Ages	2014	728	29.9%	26.8%	27.1%	21.1%		36.9%
Percentage of Deaths from Respiratory Disease, Persons, All Ages	2014	283	11.6%	12.9%	13.3%	9.7%		17.4%
Percentage of Deaths from Cancer, Persons, Aged Under 65 years	2014	139	33.7%	37.3%	38.0%	27.4%		53.1%
Percentage of Deaths from Circulatory Disease, Persons, Aged Under 65 years	2014	94	22.8%	20.7%	20.1%	14.6%		28.7%
Percentage of Deaths from Respiratory Disease, Persons, Aged Under 65 years	2014	29	7.0%	6.3%	6.5%	2.5%		11.7%
Percentage of Deaths from Cancer, Persons, Aged 65-74	2014	184	45.3%	44.6%	45.1%	34.7%		54.9%
Percentage of Deaths from Circulatory Disease, Persons, Aged 65-74	2014	105	25.9%	23.3%	24.0%	17.8%		36.7%
Percentage of Deaths from Respiratory Disease, Persons, Aged 65-74	2014	38	9.4%	12.3%	12.2%	5.2%		21.0%
Percentage of Deaths from Cancer, Persons, Aged 75-84	2014	191	27.1%	31.3%	31.5%	22.7%		38.8%
Percentage of Deaths from Circulatory Disease, Persons, Aged 75-84	2014	240	34.1%	28.5%	28.3%	20.6%		34.7%
Percentage of Deaths from Respiratory Disease, Persons, Aged 75-84	2014	95	13.5%	14.2%	14.4%	8.6%		22.1%
Percentage of Deaths from Cancer, Persons, Aged 85+	2014	167	18.4%	16.7%	16.2%	13.1%		21.2%
Percentage of Deaths from Circulatory Disease, Persons, Aged 85+	2014	289	31.8%	29.7%	30.3%	22.3%		48.2%
Percentage of Deaths from Respiratory Disease, Persons, Aged 85+	2014	121	13.3%	15.0%	15.6%	9.4%		22.1%

Evidence shows that people who die from Cancer experience a better death.

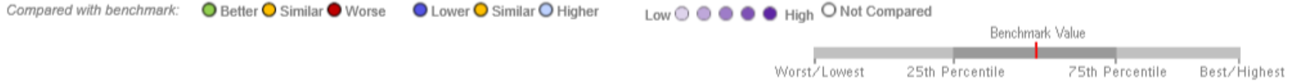
Evidence also shows that older people dying sometimes experience wide variances in quality of care and being able to express choice.

41% of cancer deaths in older people took place in hospital and only 29% of cancer deaths in older people take place in the home.[14]

A recent report by the Health Service ombudsman[15] highlighted that older people and their families may not be getting the dignified, pain free end of life care that everyone deserves.

[13] Public Health End of Life care profiles 2014
[14] Place of death from cancer by local authority for over 65 – 2011 ONS
[15] Report from HSO on ten investigations into NHS care of older people 2011

Residential Care



Indicator	Period	Wolves		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Permanent admissions to residential and nursing care homes per 100,000 aged 68-	2013/14	20	13.1	14.5	14.4	44.7		2.5
Permanent admissions to residential and nursing care homes per 100,000 aged 65+	2013/14	305	727	663	651	1,247		190
Permanent admissions into residential care per 100,000	2013/14	230	118.1	102.2	105.0	214.6		13.2
Adults in permanent residential care on 31st March per 100,000	2013/14	860	441.7	345.7	369.9	825.2		149.0
Permanent admissions into nursing care per 100,000	2013/14	95	48.8	59.8	49.2	120.0		0.0
Adults in permanent nursing care on 31st March per 100,000	2013/14	330	169.5	155.0	132.9	300.5		3.6
Adults in nursing care during the year per 100,000	2013/14	425	218	227	200	448		15
Total delayed transfers of care	2013/14	16	8.2	11.9	9.6	27.0		1.1
Delayed transfers of care attributable to adult social care	2013/14	8	4.1	5.2	3.1	13.7		0.4
Delayed transfers of care per month per 100,000	Oct 2014	17	8.7	16.6	11.6	31.2		0.0
Excess winter deaths (three year)	Aug 2011 - Jul 2014	367	16.2	16.1	15.6	25.6		3.9
Deprivation score (IMD 2010)	2010	-	34.4	-	21.7	5.4		43.4
Total resident population	2013	251,557	251,557	405,337	53,865,817	-	-	-
% of total population aged 65-74	2013	21,323	8.5%	9.6%	9.3%	3.2%		14.0%
% of total population aged 75-84	2013	14,764	5.9%	5.8%	5.7%	2.1%		8.9%
% of total population aged 85+	2013	5,873	2.33%	2.30%	2.30%	0.72%		4.01%
IDAOPI (Income Depr. - Older People)	2015	-	25.0%	-	16.2%	49.7%		6.6%

The number of unplanned emergency admissions from a nursing or residential home in 2015 was 1,785 at a cost of circa £900K

A recent report into the future of an ageing population[16] states that improvements in healthy life expectancy at ages 65 and 85 are not keeping pace with increasing life expectancy. Unless this trend is reversed, an ageing population will mean increased overall demand for health and care services.

The Personal Social Services Research Unit (PSSRU) projects that users of publicly funded home care services will grow by 86% to 393.300 in 2035.

As the population of Wolverhampton ages and the demand for services increases, there is a need to ensure that staff delivering care within the care home sector are educated and supported to appropriately manage patients within their usual place of residence (home).

[16] Future of an ageing population. Government office for Science. July 2016

Throughout Wolverhampton a range of organisations are responsible for delivering different elements of end of life care via a series of contracts.

What is working well	What isn't working well
Cross sector working of the Palliative Care Consultants	Care Coordination
Swan Care (RWT)	Further development and roll out of advanced care planning across sectors
Roll out of the GSF in an acute setting (development phase only –pilot to commence)	Further development and roll out of EPACC system across all sectors
District Nursing crisis line	GSF In Primary Care
Rapid intervention services into Nursing Homes	GSF IN Care Homes
Welfare Rights Service	Syringe Driver training & support in care homes
Housing Services	Early identification of patients approaching end life in primary care
Carer Support	
CNS Team at Compton Hospice	
Third sector agencies supporting patients with low level interventions	

In common with the rest of England, Wolverhampton's health and social care economy is experiencing unprecedented demand growth for services with limited resources to meet those demands. Despite progress in recent years, the resultant pressures are being reflected across the hospitals, GP surgeries, community healthcare teams and social services on a daily basis. As the population grows and people live longer, the challenge to balance available resources and local needs will continue to grow.

This Strategy aligns with the priorities of the City of Wolverhampton Joint Health & Wellbeing Strategy:

- Wider Determinants of Health
- Alcohol and Drugs
- Dementia (early diagnosis)
- Mental Health (Diagnosis and Early Intervention)
- Urgent Care (Improving and Simplifying)

It also aligns with the four priorities of Wolverhampton CCG:

- Improve the outcomes and cost effectiveness of planned care
- Build a sustainable and effective urgent care system
- Create a sustainable and effective system for the whole care journey of patients with long term conditions (including mental health
- Reduce the gaps in mortality across Wolverhampton

Some progress has been made toward delivering integrated care under the Better Care Fund with the development of integrated community nursing teams into Community Neighbourhood teams that include a range of services including Social Care.

This development is a positive step towards the further development of person centred integrated care for all patients including those approaching end of life.
We now need to implement this at pace across the whole end of life care pathway to ensure those nearing the end of their lives can be certain of truly integrated, person centred care when and where the choose to be treated.

A recently published report by the National Council for Palliative Care and National Voices 'Every Moment Counts', (March 2015) has adopted the following message as its guiding principle:

"You matter because you are you, and you matter to the end of your life."[17]

(Dame Cicely Saunders founder of the modern hospice movement)

Commissioners and Providers across Wolverhampton aim to ensure that this message is at the centre of the transformation of End of Life care services by ensuring that patients and their carer's are at the centre of every decision made regarding their care so that the care received is personal to them.

[17] Every Moment Counts March 2015

4. Our Vision for End of Life Care

The population of Wolverhampton approaching end of life, can be confident that they will receive person centred, integrated care from all professionals involved in their care.

Whilst a recent report has ranked end of life care in the UK as the best in the world[18], there are areas where care can be improved and made more consistent.

The General Medical Council definition of end of life care is[19]:

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

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

This would include people with dementia and all long term conditions, young people with life-limiting illness who are **transitioning** to adult palliative/end of life services, and seldom heard groups; e.g. travellers, prisoners, people with learning disabilities, minority ethnic groups.

There is increasing recognition of the particular challenges faced by young people with life limiting illness and their families in the process of transition. For young people with palliative care needs transition is particularly complex. Their independence and need to aim for personal goals are very important, but deteriorating physical health and cognitive faculties may make this a challenging prospect.

The Department of Health have identified the following definition of transition:

'…a purposeful, planned process that addresses the medical, psychosocial and educational/vocational needs of adolescents and young adults with chronic physical and medical conditions as they move form child-centred to adult-orientated health care systems'. (Blum RW et al, 1993)

The vision for End of Life care in Wolverhampton includes all of the above definitions.

There is a need to see a shift in the delivery of health and social care to empowering patients and carers through choice.

A recent review into Choice at the End of life highlights a number of key themes following wide engagement with the general public: [20]

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[18] Economist Intelligence Unit –October 2015
[19] Treatment and care towards the end of life: good practice in decision making. GMC
[20] What's important to me – A Review of Choice in End of Life Care, February 2015, The Choice in End of Life Board

- I want to be cared for and die in a place of my choice;
- I want involvement in, and control over, decisions about my care;
- I want access to high quality care given by well trained staff;
- I want access to the right services when I need them;
- I want support for my physical, emotional, social and spiritual needs;
- I want the right people to know my wishes at the right time; and
- I want the people who are important to me to be supported and involved in my care.

Commissioners and providers of end of life care in Wolverhampton should aspire to facilitating these statements for those approaching the end of their life.

All evidence shows that if patients are involved in the development of their care plan, they are more likely to be compliant with the requirements of that plan.

This strategy details the need for holistic, person centred care based on the needs and the wishes of the patient and will support services to provide care that enables patients (and carers) to be able to claim those statements.

Person Centred Care

In the delivery of person-centred care, health and social care professionals work collaboratively with people who use services. Person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and care. It is coordinated and tailored to the needs of the individual. And, crucially, it ensures that people are always treated with dignity, compassion and respect.

Adopting person-centred care as 'business as usual' requires fundamental changes to how services are delivered and to roles – not only those of health and social care professionals, but of patients too – and the relationships between patients, health and social care professionals and teams.[21]

There are a number of recognised issues associated with illness and bereavement as detailed:[22]

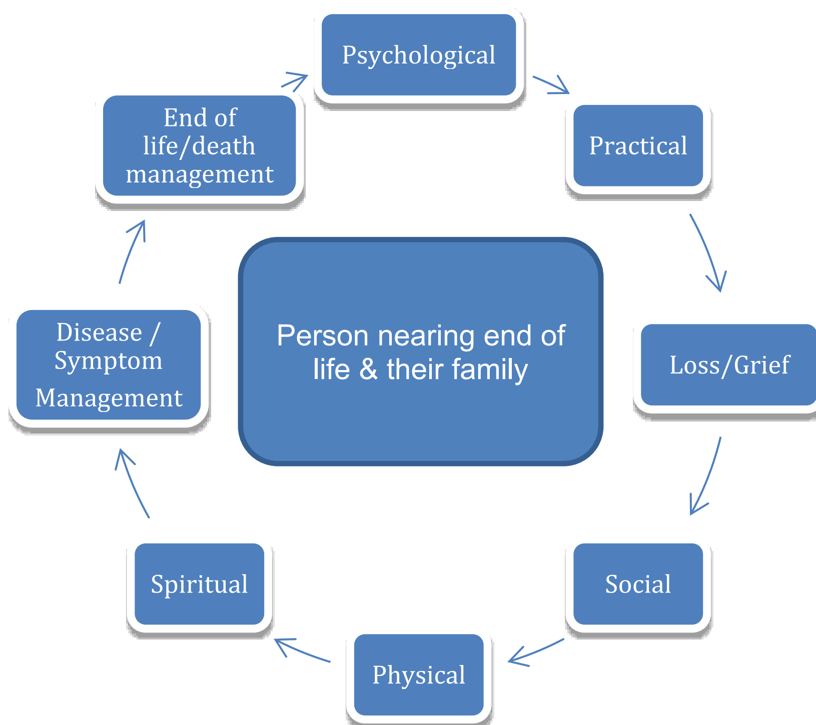

Figure 1- Issues associated with end of life care and dying

To ensure a complete approach to Person Centred care is adopted, all of the above issues need to be identified and addressed.

To do this effectively, care should be coordinated utilising a holistic advanced care plan developed in partnership with the person nearing the end of their life and the people important to them (based on the wishes of the dying person).

[21] Person-centred care made simple- The Health Foundation 2014
[22] A Model to Guide Hospice Palliative Care- Canadian Hospice Palliative Care Assc 2013

Care should be coordinated around the dying person by the most appropriate professional – irrespective of setting or organisation

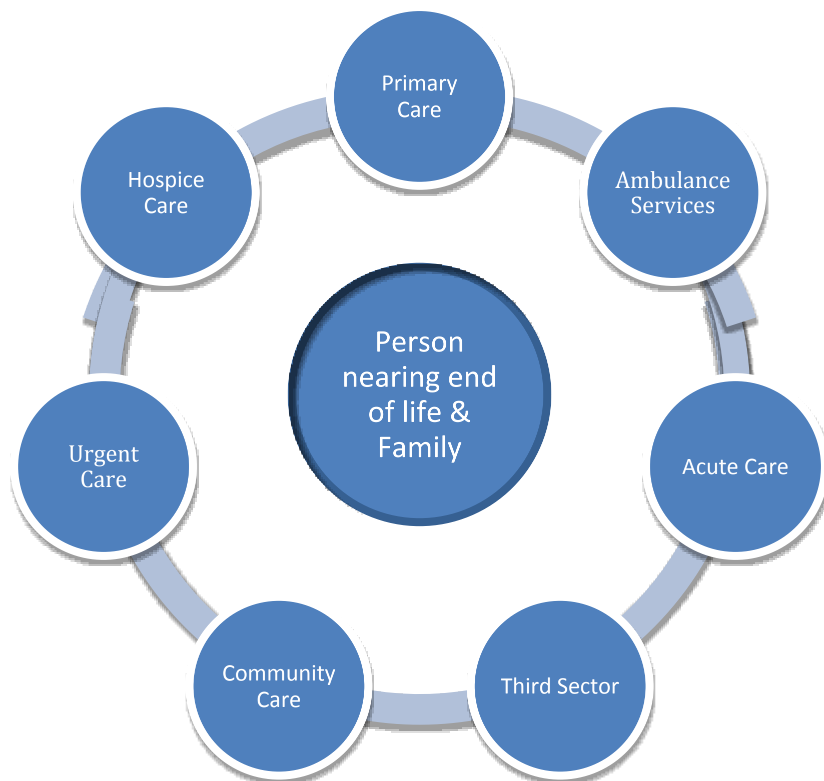

Figure 2- Providers of person centred care

Early Identification of the Dying Person

Everybody should have the opportunity for honest, sensitive and well-informed conversations about dying, death and bereavement, whether they are the person dying, their family, their carers or those important to them. We recognise that the 'when' and 'how' of such conversations need to take account of the preparedness and the perspective of the individual nearing the end of their life. However, professionals have to be sure that opportunities for honest and sensitive conversations about the future are clearly offered, irrespective of setting. Where possible these offers to talk should be early enough to enable people to reflect on their circumstances, to adapt and to plan.[23]

Each GP will have approximately 20 patient deaths per year.

About 1% of the population will die each year - e.g. with a list size of 10,000 patients, an average practice will have about 100 patient deaths/ year

Most of our patients now die from

- cancer (about a quarter)
- organ failure - heart failure, COPD etc (about a third)
- or frailty/dementia/multiple co-morbidities (about a third)

With the predicted demographic changes over the coming years, more people are living longer with serious illness, and more will die from non-cancer illnesses, often related to their long term conditions.

Improving care for patients nearing the end of their lives is one of the most important and highly valued aspects of the work in general practice. Yet until now, professionals have often failed to target care towards this group of patients, mainly because of difficulty in identifying them and responding to their needs.

There are many tools to support Primary Care with this important work; yet, the number of patients on Palliative Care registers in Wolverhampton still falls below the national average. Primary care professionals should be supported to investigate and adopt the preferred method of supporting them to improve the number of people identified as approaching end of life.

Locally we have embedded a risk stratification tool (Aristotle) within Primary care and there is also developing work across sectors looking at the frail elderly and utilising the EFI (Elderly Frail Index) tool to identify patients with a range of long term conditions and then categorise into mild/moderate/severe frailty. These tools could be utilised to support the earlier identification of the dying person.
However, tools must never override clinicians concerns for a patient.

Research by 'Dying Matters' shows that people are four times more likely to want to talk to their GP about planning for their end of life than to a solicitor, and ten times more likely than to a nurse. GPs are the gate-keepers to health services in England. If they do not plan support for a dying patient, he or she will end up in crisis

Recognising that someone is entering their last year of life benefits everyone:

[23] Ambitions for Palliative and End of Life Care, National Palliative and End of Life Care Partnership

- The patient and their carers have time to deal with the news and realign their priorities
- The patient is less likely to be subject to treatments of limited clinical value
- GPs can plan appropriate end of life care rather than deal with a series of crises
- Well organised community support can halve the cost of hospital admission and result in 70% of people realising their choice to die at home

To establish the 1% in the practice area, GPs should start with basic numbers:

- If about 1% of the practice population will die in the next year, roughly how many should be on the register?
- Death usually occurs in old age: in 2008, 62.6% of all women who died were over 80 years and 43.2% of all men; older people are a priority to consider
- Cancer only accounts for about 25% of all deaths
- Almost a quarter of all deaths are now in a residential or nursing home. People are typically already frail by the time they move into registered 24-hour care and on average die within 18 months of admission
- Some deaths will be genuinely 'unexpected': around 16% each year are in under 65-year-olds, but in over 65-year-olds only 0.25% are from 'external causes'. Many of these deaths will occur in older people with established disease, with the main causes being cerebro-vascular, acute respiratory and acute myocardial infarction
- In more deprived populations, more deaths occur in the younger ages of the older population for both men and women

QOF registers in Wolverhampton are as detailed:

Total Number of Practices	Total number of patients registered	1% of total number registered	Actual numbers on registers
45	254,713	2547.13	748 = 0.3%

Table 1

Based on 12/13 data, the following National Data applies[24]:

	Recorded prevalence (QOF 2012/13)	Expected prevalence (2012/13)	Estimated under recording (percentage)	Projected prevalence based on expected prevalence			
				2014	2015	2016	2021
England	130,233 (0.2%)	339,647 (0.6%)	69%	338,305 (0.6%)	338,156 (0.6%)	338,380 (0.6%)	344,936 (0.6%)

Table 2

There is a need to promote earlier identification of patients nearing the end of their life in primary Care to ensure appropriate care planning takes place.

[24] Quality and Outcomes Framework (QOF) for April 2012 to March 2013, Quality Management and Analysis System (QMAS) database – 2012/13 data as at end of June 2013

As part of the CCG Primary Care Strategy, it is recognised that there is a need to develop the workforce in Primary Care to ensure the City has the right clinicians with the right skills available in the right quantity in the right place.

NHSE General Practice Forward View[25] provides some detail on plans to expand and support GP's and wider Primary Care staffing.

The plans are to target a range of clinical staff across Primary care with investment from the sustainability & Transformation fund. This includes the development of the capability of the current workforce.

To enable Primary care to take its place at the forefront of the delivery of good end of life care, this strategy outlines plans to place education and development in end of life care front and centre of workforce planning.

Only well-trained, competent and confident staff can bring professionalism, compassion and skill to the most difficult and intensely delicate physical and psychological caring.[26]

To ensure that Primary Care professionals are appropriately staffed and skilled to undertake this important role and the wider role of a Primary Care clinician, the CCG is currently undertaking a detailed workforce analysis programme.
The outcomes of the analysis will form an integral part of the Primary Care workforce development.

To give care day in and day out requires organisational and professional environments that ensure psychological safety, support and resilience.

Specifically, in relation to End of Life care we aim to:

- Immediately deliver training to support having difficult conversations
- Ascertain the possibility of providing resource to support improved coding of palliative and end of life patients

[25] NHSE General Practice Forward View April 2106
[26] Ambitions for Palliative and End of Life Care, National Palliative and End of Life Care Partnership

Advance Care Planning

Caring for people at the end of their lives is an important role for many health and social caring professionals. One of the aspects of this role is to discuss with individuals their preferences regarding the type of care they would wish to receive and where they wish to be cared for in case they lose capacity or are unable to express a preference in the future.

These discussions clearly need to be handled with skill and sensitivity.
The outcomes of such discussions then need to be documented, regularly reviewed and communicated to other relevant people, subject to the individual's agreement.[27]
ACP is a process of discussion between an individual and their care providers irrespective of discipline.

The difference between ACP and planning more generally is that the process of ACP is to make clear a person's wishes and will usually take place in the context of an anticipated deterioration in the individual's condition in the future, with attendant loss of capacity to make decisions and/or ability to communicate wishes to others.

Examples of what an ACP discussion might include are:

- the individual's concerns
- their important values or personal goals for care
- their understanding about their illness and prognosis, as well as particular preferences for types of care or treatment that may be beneficial in the future and the availability of these

In Wolverhampton an integrated ACP has been developed across all partners including patients and carers.

This document includes a wide range of personal information about the dying person in conjunction with the clinical, social information requirements of the professionals providing care.

Comment from a focus group member

It's a bit of a 'gloomy' document. It needs brightening up a bit with a few pictures to make you want to read it and fill it in

Comment from a focus group member

Really good document and the section for the patient/carer to complete is really good. However, how are we going to ensure that patients/carers bring it with them to appointments?

[27] Advance Care Planning: A Guide for Health and Social Care Staff. Nat End of Life Care Programme

Shared Care Record

As the end of life approaches, individuals and families must be able to rely on safe, appropriate care that is consistent with their wishes, at any time of day or night and no matter who is providing this care.

The 2008 National End of Life Care Strategy recommended locality registers as a way to enable effective communication among professionals.

From this experience grew the Electronic Palliative Care Co-ordination Systems (EPaCCS), which are now being implemented across the country.

EPaCCS provide a shared locality record for health and social care professionals. They allow rapid access across care boundaries, to key information about an individual approaching the end of life, including their expressed preferences for care.

EPaCCS provides a National information standard defining the core data set required.

A case study of a pilot in Bedfordshire saw a central electronic register was established containing relevant information on those in the last year of life to which all services would have access. The pilot proved successful in highlighting the fact that a central register supported coordinated care and increasing the amount of people able to die at home.

Some of the findings of the recent final evaluation report into EPaCCS are[28] ;

- An indication that patients, carers and professionals in EPaCCS locations suggest that co-ordination of care is both important and increasingly being realised;
- That EPaCCS may bring an additional degree of system integrity;
- That given the evaluation design and methodology there is as yet no conclusive evidence of system-wide impacts on indicators such as deaths in hospital that can be distinguished between EPaCCS and non-EPaCCS sites;
- That there is reason to believe that overall costs associated with EPaCCS and its impact are unlikely to increase and that therefore the case for further development is good;
- That to achieve full benefit from EPaCCS a number of contextual and cultural challenges need continuing emphasis including the building of capability amongst staff, taking full advantage of technological advances and overcoming the complex nature of end of life care service delivery through building strong teams that collaborate effectively across agencies, organisations and professions

To ensure the advanced care plan can guide a person centred approach, it has to be available to that person, so that they can review, change and update it themselves.

Subject to that person's consent, or, if they lack mental capacity, in their best interests, the plan should also be shared with all those who may be involved in their care. All electronic systems for sharing health related preferences must encompass the recording and sharing of preferences at the end of life.

To ensure a better response to dying, death and bereavement, the local organisations that give care need accurate and up to date information that can help them improve services.

[28] Independant evaluation of EPaCCS in England March 2016

Locally, very little has progressed with the further development and roll out of this and so there is an urgent need to accelerate this work and start the shift towards an integrated electronic patient record for those approaching the end of life.

More work is required to map all stakeholders requiring access to a shared care record and some consideration to how we enable care homes and the voluntary sector to provide holistic care based on the persons wishes.

Coordinated Care

A local carer's experience

My mom was discharged from hospital following a discussion with a Consultant advising that a prolonged stay in hospital would not be in her best interests and would we like to take her home?
We welcomed this conversation.
We agreed and she was discharged.

We then had to begin the battle of trying to get a special mattress from the Independent Living Service. Following delivery of the wrong size mattress, numerous calls to get it replaced finally realised delivery of the correct size. The only problem was, they delivered it to my parent's house and 'dumped' it in the spare room. They were not allowed to put it on the bed! My father was 80+ years and not capable of changing the mattress himself, so, a very kind neighbour came in to help.

The first visit by a District Nurse gave us hope as she said that in her opinion, there was now a need to increase the frequency of visits to mum.
The following week (a whole week on), a more senior District Nurse visited and told us that she was discharging mum because 'her legs were now better'
What about the rest of her care? She was in the last days of life.

We had to admit her to hospital on the Saturday because she had a fall. Social Services couldn't (or wouldn't) help with support and neither would the District Nurses.
My mom wanted to die at home, but she eventually died in the local Hospice on the day she was transferred there from the local hospital.

The care received there was exceptional.
It's just a shame it came so late.
Both my mom and my family were greatly let down by services at this traumatic time.
Things have to change

Time after time reports tell us that care for people nearing the end of their life remains fragmented and is delivered in silos and that people nearing the end of their lives and those close to them have to repeat information numerous times.

This continues to create anxiety and issues with continuity of care.

Effective systems for person centred care need to encompass: systematic ways of reaching people who are approaching the end of life, effective assessment as well as effective decision making support, care coordination, care planning, and care delivery.

It also requires effective ways of managing the timely and sometimes repeated input of Specialist Palliative Care services or dedicated children's palliative care services, when needed. Such systems should identify the goals of the person nearing death.

Part of the approach should include the appropriate use of person centred tools to measure the quality and impact of care on the dying person within the context of local audit and reflection.

There are a range of tools available to measure person centred care:[29]

- Ambulatory Care Experiences Survey
- Baker and Taylor Measurement Scale
- Barriers to Providing Family-Centred Care
- Benchmarking Person-centred Care

There is no 'one size fits all' tool and a range of tools should be applied to obtain a whole view.

People nearing the end of their life and their family, want to be able to access services when they need them and not have to navigate their way through a myriad of professionals and contact numbers.

Services need to be flexible and responsive, with access to key services 24hrs per day.

People nearing the end of their life should know what they can expect from Health & Care services in Wolverhampton. Those who commission local systems of care should tell people what they might reasonably expect of their health and care services as they approach death.

The distress of uncontrolled pain and symptoms cannot wait for 'opening hours'. This is a necessary system-wide expectation and good end of life care cannot be achieved without it.

The shift to provide 24hr access to services has already started with the Community based services in Wolverhampton under the BCF programme. This needs to be built upon, at pace, to ensure all services are accessible and responsive.

To ensure we can deliver coordinated care to the people of Wolverhampton we have to ensure that each person nearing the end of their life, has a named care coordinator who will ensure that the health and care needs and wishes of the dying person are coordinated and delivered in accordance with the care assessment.

The details of this care coordinator must be available to the dying person and those closest to them to ensure a swift response in times of crisis or times of anxiety and stress to provide reassurance and support.

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[29] The Health Foundation – Helping measure person centred care 2014

Symptom Management

Care Home Manager – Wolverhampton
We recently had two patients who died without pain relief.

Our staff are not trained to administer drugs via a syringe driver.
This is an issue locally as District Nurses are not commissioned to support nursing homes with pain relief.

Key to symptom management is the role of the Palliative Care team.

Palliative Car is the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatment. [30]

The core role of the palliative medicine physician may be defined as the medical assessment of distress, symptom management and end of life care for patients with complex clinical needs due to advanced, progressive or life threatening disease. They provide medical leadership within palliative care services and hold clinical responsibility for the treatment of patients in their care. Areas of responsibility include ensuring good quality, efficiency and equitable access to services, advising on strategic planning including commissioning of services, and developing strategies for research, education and training in relation to specialist and generalist palliative care.[31]

In 2015, NICE updated their guidance on the symptom control of the dying person[32].

This guideline includes recommendations on:

- recognising when people are entering the last few days of life
- communicating and shared decision-making
- clinically assisted hydration
- medicines for managing pain, breathlessness, nausea and vomiting, anxiety, delirium, agitation, and noisy respiratory secretions
- anticipatory prescribing

This Strategy recommends the full implementation of this guideline in conjunction with the Five Priorities of Care as developed by the Leadership Alliance for the care of the dying in their report 'One Chance to Get it Right'. These make the dying person themselves the focus of care in the last few days and hours of life and exemplify the high-level outcomes that must be delivered for every dying person.

[30] National Council for Palliative Care
[31] The role of the Palliative Medicine Consultant. Assc for Palliative Medicine 2012
[32] Care of dying adults in the last days of life NICE guidelines [NG31] December 2015

The Priorities for Care are that, when it is thought that a person may die within the next few days or hours;

- this possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
- Sensitive communication takes place between staff and the dying person, and those identified as important to them.
- the dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
- the needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
- an individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

There is also a need to ensure that optimal symptom control is delivered throughout the dying phase to ensure that the patient can live the best quality of life and is enabled to live well.

Anticipatory Prescribing is the mechanism by which health professionals ensure that those approaching the end of their lives have access to the medications they will need in a timely manner.

It is recognition that all people approaching the ends of their lives have the potential to develop symptoms and that the correct medication with correct dose is available to address these symptoms.
Anticipatory prescribing occurs on an individualised, case-by-case basis, generally when it is thought that someone is within the last days to limited weeks of life (but timing / appropriateness will be dependent on various factors, including geographical location etc).

In Wolverhampton clinical professionals have developed an approved list of medications to be used across the city.

Out of hours medication is held in the Urgent Care Centre with access for GP's and District nurses to pain management drugs.

In addition there are a number of Community Pharmacists commissioned to hold and dispense an agreed list of medications to enable symptom control in the community.

It is the vision of Commissioners and Providers of health & social care in Wolverhampton that all people at the end of their lives should have a good death and that we can confidently state that we supported those nearing death and their carers to 'make every moment count'.

Bereavement Care

Good palliative and end of life care includes giving care and support to families, friends, carers and all those who are important to the dying person.

This must encompass good bereavement and pre-bereavement care, including for children and young people. It must also respond to the needs of those who are affected by death caused by sudden illness or trauma, including suicide.

Although some bereavement care is delivered through Compton Hospice, this is not routinely available to all – only those whom have accessed care at the Hospice.

Commissioners of services may wish to consider commissioning bereavement services that are accessible to all.

District Nursing Teams across Wolverhampton report some delays in verification of death causing distress to relatives and loved ones.

It is crucial that all services respond to these calls as a priority to avoid unnecessary distress and anxiety.

It is recognised that if a competent registered nurse can verify expected patient death, increased quality of care can be offered both to the patient, relatives and carers.

The Nursing and Midwifery Council (NMC) advised that "nurses can confirm that death has occurred, provided there is an explicit local policy or protocol to allow such an action and only in cases where the death is expected." (NMC 2008).

Commissioners of services may wish to consider commissioning this service to enhance the quality of services at this difficult time.

End of Life Care Workforce

Comments from a local focus group

'Consultants won't let patients go and offer them unnecessary treatment and hope'

'Clinicians will not have the difficult conversation and leave it to the nurses'

When you ring Social Services, the first question is 'do you have over £23k in the bank?. If so, we can't help you'
They do not provide help and support to access privately funded provision.

Every professional needs to be competent and up to date in the knowledge and practice that enable them to play their part in the delivery of good end of life care.

End of Life Care (EoLc) cuts across specialisms, settings (hospital, care home, community and hospice), workforces (nurses, social care workers, ancillary staff, GPs, specialists) and geographies.

While many parts of the health service deliver excellent EoLc, the risk of an endemic culture of neglect and poor practice in certain environments has devastating consequences for patients: a minimum level of skills in EoLc across all workforces and settings was one of the themes of a recent report into the education of those delivering EoLc by The Democratic Society for Health Education England[33].

Commissioned annual training should focus on up skilling generalists, as appropriate, in the recognition of dying patients, difficult conversations, pain management and personalised care planning. In terms of efficacy, we recognise that a blended learning approach can improve the proficiency of students and qualified staff. Learning that is reinforced through different opportunities and approaches ensure that key ideas are embedded. The most important skill cited by participants was communication and this is a clear focus for any training strategy. Strengthening mandatory training for both EoLC and communication (as a universal skill) early in the clinical learning paradigm was seen as critical, as was focusing subsequent reinforcements of this throughout educational strategies.[34]

This report highlighted eight key themes regarding education for those delivering EoLc:

- Extend the workforce for delivery of EoLC
- Define, develop and disseminate information about the role of HEE and the LETBs;
- Develop relationships and strategic partnerships to support network building in EoLC;
- Create a hub for EoLC education and training resources;
- Improve awareness of and access to funding;
- Focus on communication skills as a universal skill underpinning EoLC;

[33] The Democratic Society for HEE
[34] The Democratic Society for HEE

- Create a baseline of EoLC tools; and
- Support Blended Learning to deepen knowledge in EoLC.

Health Education England's Palliative and end of life care education and training strategy[35] highlights the recommendations of the Francis Report (Francis R 2013)
The report recommends that organisations should:

- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated;
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff who have to provide the service;
- Ensure openness, transparency and candour throughout the system about matters of concern;
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards;
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do;
- Ensure that the public are protected from those not fit to provide such a service;
- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field;
- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do;
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system;
- All health and social care support workers must undergoing fundamentals in care training before being allowed to care for patients;

For some, these recommendations require a major shift in attitudes to care delivery; education and training should give staff an opportunity to explore and embed these skills.

The Nursing and Midwifery Council has updated the Code of Conduct for nurses and midwives to highlight the importance of delivering fundamental care to dying people so that they can expect to receive the high standard of care afforded to any other person needing nursing care.

"Anyone training to be a nurse in the UK is required to demonstrate that they can deliver care safely, competently and with compassion. Following the publication of More Care, Less Pathway in 2013 we published our standards for competence to make the public aware of the fundamental standards of care that a nurse is expected to be able to deliver. In addition, as part of the review of our Code, we have incorporated these standards into the draft to make sure that all nurses registered in the UK, regardless of where they trained, understand what the public expect from them." Jackie Smith, NMC Chief Executive and Registrar, 2014.

[35] Palliative and end of life care education and training strategy. March 2015

The recent Cavendish Report (Cavendish, 2013) provided an independent review into healthcare assistants and support workers in the NHS and social care settings and goes on to make a number of recommendations in relation to HCA's, Social Care Staff and Care Home staff. The report proposes minimum standards of competence before staff can work unsupervised, in the form of the "Certificate of Fundamental Care".

The recommendations of the Francis and Cavendish Reports and the Chief Nurse's 6 Cs, translate easily to all areas of care especially end of life care. The NHS core values (NHS, 2013) embed much of the recommendations of these reports cited above; end of life care education and training should aim to embed these values.

A recommendation of this strategy is to ensure that Commissioners and Providers of End of Life care develop strong working relationships with the local LETB's to ensure Wolverhampton is first in line to access any training and education to support front line staff

Access to Social Care

People approaching end of life must be supported with rapid access to needs-based social care. The reality of care at the end of life is that it encompasses what professionals see as a mix of 'health' needs and 'personal and social care' needs. Expertise in both is important for the best clinical assessment of need and the best delivery and management of hands on care.

The 2010 report into a study by the Nuffield Trust into the use of Health & Social Care services at end of life[36] found the following:

Level of uptake of social care:

- On average, 30 per cent of the people in the study group had some form of local authority funded social care service in the 12 months prior to death. For older people this proportion exceeded 40 per cent
- There were marked differences in the use of local authority-funded social care between the three study PCT/local authority areas with one area showing much lower overall use
- The numbers of people accessing local authority-funded social care in any one month gradually increases over the last 18 months of life
- The proportion of the group accessing any social care in any one given month increases from 15 to 30 per cent during this period
- A large proportion of the increase in social services used in the last twelve months can be attributed to increases in the use of care homes and medium-intensity home care services

Interactions between hospital and social care:

- For the cohort of 16,479 people – in the last year of life 7.2 per cent of the group accessed only social care, 49 per cent accessed hospital inpatient care and 23 per cent used both types of services
- Use of local authority-funded social care increased gradually in the last 12 months of life, whereas use of NHS funded inpatient hospital care sharply increased, particularly in the final two months
- The balance of hospital inpatient and social care costs shifted dramatically with increasing age
- Above age 60, hospital costs at the end of life declined with increasing age, while social care costs increased
- A crossover occurs in people aged 90 and above when estimated social care costs in the last year of life exceed the hospital inpatient costs
- There is some evidence across all age groups that higher social care costs at the end of life tend to be associated with lower inpatient costs
- There were marked differences between the three sites in terms of the balance of hospital and social care costs. The area with the highest social care costs had much lower hospital inpatient costs which may reflect substitution of services.

Differences in social care use with long-term conditions:

[36] Social care and hospital use at the end of life, The Nuffield Trust, 2010

- The use of social care differs according to the presence of certain long-term conditions;
- people with mental health problems, falls and injury, stroke, diabetes and asthma tended to use more.
- People with cancer appeared to use local authority-funded social care the least – an effect not simply due to the younger age profile of these cases.
- Though the number of long-term conditions a person has is related to higher hospital costs, it appears to be unrelated to social care costs

The concept of meeting the person's needs recognises that everyone's needs are individual and personal to them.

Asset based assessments are completed with recognition to the importance of the individual participating as fully as possible in decisions about them and to them being provided with the information and support necessary to enable the individual to participate.

Care and support should be personal, and local authorities should not make decisions from which the person is excluded. Beginning with the assumption that the individual is best placed to judge the individuals wellbeing Building on the principles of the Mental Capacity Act, the local authority should assume that the person themselves knows best their own outcomes, goals and wellbeing.

The principle of wellbeing must be embedded throughout the social care system (Care Act 2014).

For the above reasons, and more, it is imperative that Wolverhampton Local Authority are partners in the development and redesign of End of Life care services across Wolverhampton.

Great strides have been made in Wolverhampton to move towards integrated Commissioning across Health & Social Care through the BCF Programme.

This work has enabled a greater understanding of the issues each organisation faces with regard to providing care and support to the population of Wolverhampton.

To this end, both organisations have developed a set of shared goals and values and are:

Working together in better ways to put health and social care systems on a steady footing, translating improved outcomes for customers into long-term, sustainable support for our communities as a whole is fundamental to Wolverhampton's approach.[37]

Domicillary Care

Patients nearing the end of their lives may need some support to carry out the basic daily living needs.
Domiciliary care is defined as care provided to someone in their own home.
The aim of domiciliary care is to enable people to remain living as independently as they can be in their own homes through the provision of personal care and support.
This may include care and support with daily personal tasks including with medication, however care and support will be predominantly non-medical.

[37] BCF Submission 2016

The support provided should be of a re-ablement nature when appropriate and will be tailored to suit the individual's needs.

Carers

Feedback from a local carer

"Trying to hold down a full time job and care for someone who is dying is a considerably stressful time and looking back
I don't know how I did it, I eventually had 2 weeks off sick but trying to get a sick note off the doctor was stressful in itself even though it was the same doctor as mum although a different surgery - why can't the doctor treating issue a sick note"

A carer is anyone who provides a significant amount of support for a relative, friend or neighbour on a regular basis without payment. The person that you look after may have a mental health need, learning disability, physical and sensory disability or may be an older, vulnerable person[38].

Wolverhampton City Council offer a range of support to carers via the carer support team:

- Practical information and advice
- Carer's assessment
- Benefits advice
- Signposting
- Carer's emergency card

Adults

Information and support for adults and those that are caring for them.

Advice and Information
Health Matters
Keeping Safe

Children, Young People and Families

Information and support for families with children and young people aged 0-19.

SEND Local Offer

Information and support for children & young people with special educational needs and disabilities aged 0-25.

Advice and Support

[38] Wolverhampton City Joint Carers Strategy August 2016

Adult Carers

Across the UK today 6.5 million people are carers, supporting a loved one who is older, disabled or seriously ill. In Wolverhampton alone it is estimated that there are around 27,500 carers.

It is important that end of life care services enable carers to access support to carry on with their life whilst undertaking their caring role.

The Wolverhampton Joint All Age Carer Strategy 2016 – 2020, 'Who cares? We do' [39] Recognises that carers play a critical role in supporting someone who would otherwise be unable to look after themselves; often putting the needs of the cared for before themselves.

It is also recognised through national research, and more locally from talking to carers, that caring impacts on their quality of life.

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

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

In Wolverhampton unpaid carers provided support to the value of £594 million per annum.

[39] Wolverhampton Joint All Age Carer Strategy 2016 – 2020 – September 2016

City of Wolverhampton Integrated End of Life care

Early identification of person Identification: Prognosis – years / months Identification of Palliative and Supportive Care needs during regular LTC reviews, use of SPICT or GSF Prognostic Indicator Guidance “Surprise Question”. Inclusion on Supportive Care Register (Green) / Initiation of ACP discussions Identification of life-limiting diagnosis and palliative care needs on letters (admission, hospital OPA or discharge) / new referral to Specialist Palliative Care communicated nearing the end of their life

Supportive Care Register entry- (green – stable)

Months to live

Inclusion on Supportive Care Register and reviewed at MDT minimum 8 weekly
Care coordinating professional identified
Clinician completes: Holistic assessment, discusses aims and priorities for care, and care plan (ACP) for palliative needs with patient.
Review dates appropriate to patient condition and setting.
Timely referral to specialist palliative care services
Electronic notes for palliative care, and communication with Out of Hours

Supportive Care Register updated - (amber - Unstable).

Months/Weeks to live

Care Plan review at MDT and as necessary.
Clinician reviews patient and family holistic needs and personalised ACP. Discuss Preferred Place of Care and Death, and Resuscitation Options including DNACPR form.
Review date agreed appropriate to patient condition.
Timely referral & liaison with specialist palliative care and support services Additional support from Hospice at Home or 24 hour nursing / support services in community if necessary
Anticipatory medications prescribed and equipment provided as necessary

Supportive Care Register updated-
(red – deteriorating/dying)

Days/Hours to live

Care plan for care in the dying phase initiated.
Minimum daily review
(5 Priorities for Care). Focus on providing personalised care with dignity.
Resuscitation Options / DNACPR paperwork reviewed
Information shared with MDT
Additional support available from Hospice at Home or night sitting support services or District Nurse crisis service in community
Anticipatory medications and equipment in place as necessary

Post Death and bereavement

Verification of death completed promptly and appropriate services notified
Body cared for in a culturally sensitive and dignified manner
Timely issue of Death Certificate
Carer information on registering a death and bereavement support
Complete electronic record indicating place of death.
Reflection and learning reviewed at next service or practice MDT meeting
Audit patient outcomes

Holistic support, Carer Support, pre-bereavement and bereavement care: Cultural and spiritual needs identified through holistic assessment. Identification of Carers. Carer needs regularly assessed and referral for support if appropriate. Immediate and on going bereavement emotional and spiritual support

24 hour access to support and information with adequate workforce to deliver person centred care

It is recognised and acknowledged that patients will shift through these phase on an individual basis in line with each disease trajectory.
It is not the intention of this strategy to promote a ‘one size fits all’ model of care.
It is essential that patients approaching the end of their lives are assured that all End of Life care services are responsive and timely throughout their end of life journey.

If care is coordinated around the dying person, then appropriate support will be available at each transition point of the patients journey.

5. Delivering the Vision

To achieve equitable access to high quality, consistent Palliative and End of Life Care for patients when they need it, a local standardised model for Palliative and End of Life Care has been developed (above) which, when delivered, will be a step towards equitable service provision and facilitate greater coordination of care.

This model encompasses an end to end approach to care, commencing with early identification of the dying phase in Primary Care through to post bereavement care.

Successful delivery of the strategy will achieve the following key outcomes for people nearing the end of their life and support the system outcome ambitions.

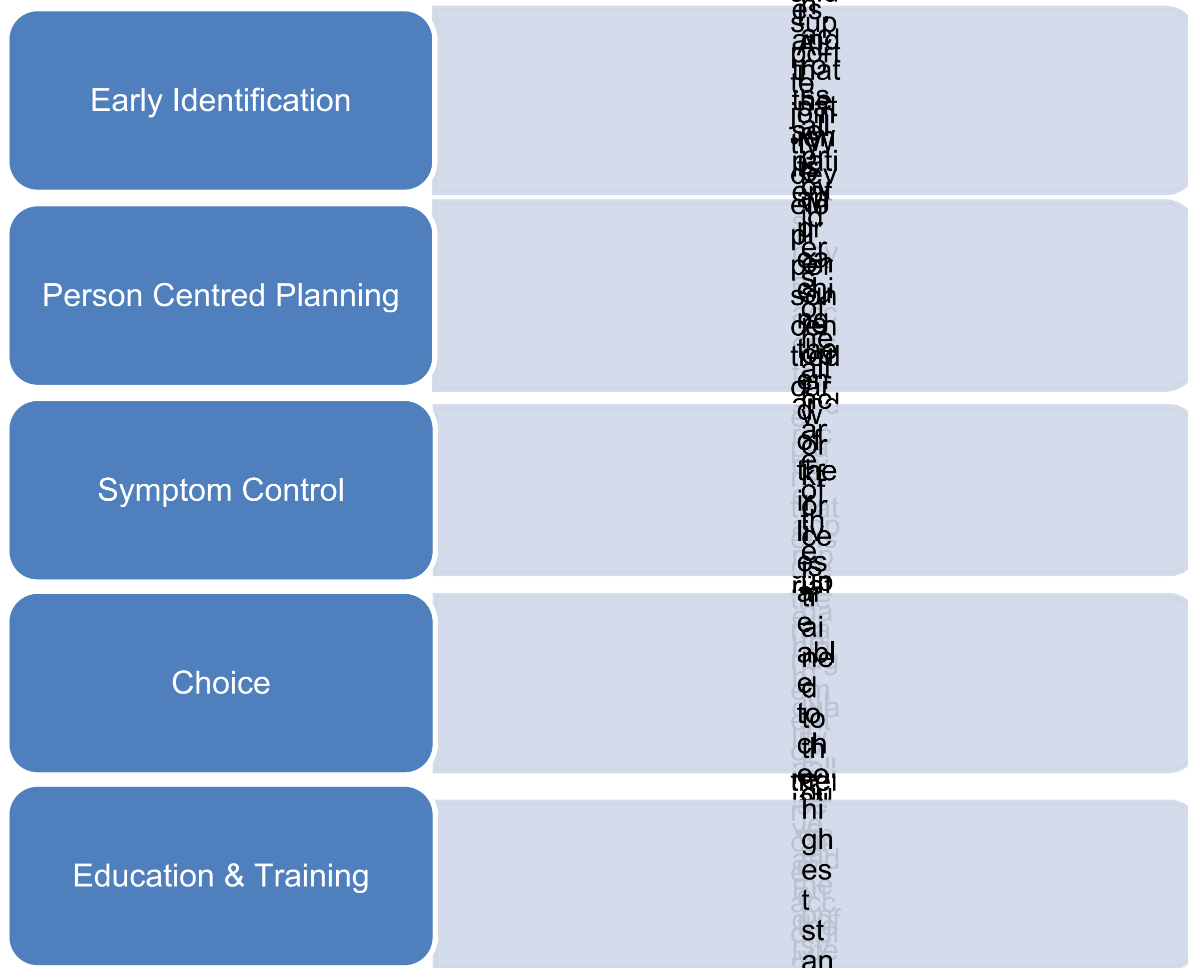

Figure 3: Key outcomes for Palliative and End of Life Care

More detailed outcomes will be included in the End of Life care Outcomes Framework.

Carer experience

My father in law was a very educated, articulate man.
He had suffered for many years with his long term condition and knew that he was nearing the end of his life.
He had voiced his wishes and choices regarding his death and had completed a DNAR.

During a period of an exacerbation of his condition, he was admitted to the local Hospice where we were told 'this is it'.
The care he received in the hospice was outstanding.
The care we received as his family was outstanding.

Quite remarkably, the clinical staff managed to stabilise his condition and bring his symptoms under control.
We were then told that he was to be discharged.

This came as a great shock as we believed he was to be in the hospice until he died. This was probably an assumption on our part.

So, my father in law decided he would prefer to go into a nursing home rather than home as my mother in law was unable to cope due to her own health issues.

We then set about trying to find a suitable home.

We weren't pressurised by the hospice, but we felt under4 pressure to move him quickly to free up the bed.

We found a suitable home and arranged for him to be transferred.

It was at this transition point that things went horribly wrong. All of his wishes regarding his death were not transferred with him and indeed when the paramedics were called during an acute phase, they tried to resuscitate him.

This caused great distress to the family and I am sure that had my father had completed an ACP that he held, this would have transferred with him and all of the anxiety and upset could have been avoided.

The Coordination Hub

A key element to the coordination of care if the central function of a coordination point.

Building on the work already in development to co locate the Community Neighbourhood Teams in each of the three localities across Wolverhampton, it is our intention to utilise this model as the coordination point for End of Life care services.

A number of key end of life care services will already be locality based providing local services to local people (e.g District Nursing). Therefore, it is recognised that there is room for future development of these contact hubs to include the coordination of End of life care services.

This would enable the use of one contact number per locality for both professionals and patients.

- A single contact number per locality
- Access to registered patients
- Access for help/advice/support
- Specialist professional support
- Support for Primary Care

There is a range of evidence proving that coordinating care for those at end of life ensures improved outcomes in patient experience, symptom management, timely response from integrated services and timely communication to aid the delivery of good quality care.[40][41]

There are a number of models nationally that could be adopted across Wolverhampton. Consideration should be given to the development of a local offer of end of life care utilising a place based approach.

This approach will enable the delivery of a range of services based on population need. Statutory services will be supported by a wide range of third sector services and social prescribing to enhance the level of service provision.

[40] PEPS service Bedfordshire
[41] Greenwich Care Partnership

Phases of Illness/Currency for Palliative Care

An example of a clinical measure for patients nearing the end of their lives has been developed in Australia has recently been validated as a reliable and acceptable measure that can be used for palliative care planning, quality improvement and funding purposes.

Table 3 contains the definitions from this study.

A person at the end of their life may have more than one phase of care within a spell of care. One phase ends and another begins when a clinical decision is made that the person has moved between one of four phases of illness – Stable, Unstable, Deteriorating and Dying.

The Australian Model[42]

The recommendations around developing a currency model based on phase of illness came from looking at the model utilised in Australia under the Australian National Sub-Acute and Non-Acute Patient classification 5 (AN-SNAP).

The Palliative Care Funding Review identified the similarities between British and Australian palliative care need. The ANSNAP model identified the key cost drivers for palliative care to be phase of illness, age, functional status and severity of problem.

NHS England have utilised this study as the basis for their ‘discussion on developing a tariff for palliative care.

[42] http://ahsri.uow.edu.au/Publications/pre2001_pubs/snapstudy1997.pdf

Phase of Illness Criteria

Phase	Start of phase	End of phase
Stable	• Patient problems and symptoms are adequately controlled by established plan of care and: • Further interventions planned to maintain symptom control and quality of life; and • Family/carer situation is relatively stable and no new issues are apparent	The needs of the patient and/or family/carer increase, requiring changes to the existing care plan (i.e. the patient is now unstable, deteriorating or terminal)
Unstable	An urgent change in the plan of care or emergency treatment is required because: • Patient experiences a new problem that was not anticipated in the existing plan of care; and/or • Patient experiences a rapid increase in the severity of a current problem; and/or • Family/carers' experience changes which impact on patient care	The new care plan is in place, it has been reviewed and no further changes to the care plan are required. This does not necessarily mean that the symptom/crisis has fully resolved but there is a clear diagnosis and plan of care (i.e. the patient is now stable or deteriorating); and/or • Death is likely within days (i.e. patient is now terminal)
Deteriorating	The care plan is addressing anticipated needs but requires periodic review because: • Patients overall function is declining and • Patient experiences an anticipated and gradual worsening of existing problem and/or • Patient experiences a new but anticipated problem and/or • Family/carers experience gradual worsening distress that is anticipated but impacts on the patient care	Patient condition plateaus (i.e.. patient is now stable) or • An urgent change in the care plan or emergency treatment is required and/or • Family/carers experience a sudden change in their situation that impacts on patient care, and requires urgent intervention (i.e. patient is now unstable) or • Death is likely within days (i.e. the patient is terminal)
Dying	Death is likely within days	Patient dies or • Patients condition changes and death is no longer likely within days (i.e. patient is now stable or deteriorating.)

Table 3

**It is recognised that patients will pass between phases whilst approaching the end of their life. Each patient is unique and we will ensure that our services are responsive enough to meet each need*

Children Transitioning to Adult Services

The 'Transition Taskforce' (2012-2015) commissioned by Together for Short Lives[43] mission is to *overcome the barriers to good transition for young people with life-shortening conditions, by building and strengthening bridges between adult and children's services and that they will make the transition to adult services and live their lives as independently as possible according to their wishes, while receiving the care and support they and their families need.*

Commissioning children's palliative care - A guide for Clinical Commissioning Groups states that Children's Palliative Care services should be:

- flexible and focused on children, their parents and their siblings.
- accessible 24 hours a day, seven days a week, 365 days a year – from diagnosis or
- recognition to bereavement.
- supports and enables children and families to choose the type, location and the provider of the care they receive and allows them to change their mind.
- not age, time or diagnosis specific – 15% of children who need CPC have no definitive underlying diagnosis.
- multi-disciplinary and multi-agency.
- accessible to people of different faiths, culture, ethnicity and locations.
- Include pre and post-bereavement support for families
- able to manage symptoms.
- supports parents in caring for their children according to their needs and wishes
- supports and enables smooth transitions for young people with life-limiting and life threatening conditions who move from children's to adult's services

40,000 children in England live with a life-limiting or life-threatening condition

Children dying in Wolverhampton		
Age Range	2013	2014
Under 15yrs	4	23
Over 15yrs	24	1

Wolverhampton CCG commission children's end of life care services from Acorns Hospice.
The service aims and objectives are:

- Works with families who have a life-limited or life threatened child who is expected to die before his or her 18th birthday.

- Aims to work with families in a direct response to their expressed needs in palliative care and bereavement support, being committed to a family led service where clients and families are viewed as partners in the care offered.

[43] The 'Transition Taskforce' (2012-2015) commissioned by Together for Short Lives

- Offer planned palliative short breaks, emergency short breaks, end of life care, day care, hospice outreach care, community psychosocial support, transitional support and access to hydrotherapy and physiotherapy and, where appropriate interpreters.

- Strive to work collaboratively with professionals from other care agencies who may already be involved with a family at the time their child is referred to Acorns.

- Support families to access treatment for pain and symptom control for specialist complex health conditions

- Provide emergency / crisis support both for medical and social emergencies

- Reduce hospital admissions via planned short-breaks and emergency admissions to the hospice

- Provide transitional support for young people from the age of 14 years and their families, supporting them to access adult palliative care services post 18 years

- Reduce family isolation and increase support network

- Strengthen family health and wellbeing

- Reduce family breakdowns by offering consistent and comprehensive support

- Provide bereavement counselling and support to families

- Support children & young people to enjoy life.

Commissioning for smooth transitions and age-appropriate care for young people with life-limiting conditions in England 'A guide for Clinical Commissioning Groups' [44]
Many young people with life-limiting conditions and their families find transition daunting. On leaving the comprehensive care offered by children's services, they will often have to deal with and establish important relationships with a range of unfamiliar agencies and professionals. The result can be gaps in services or fewer or less appropriate services[45].

For many young people with life-limiting conditions, transition into adult services often coincides with a rapid decline of their condition and eventual death.

As such, they have specific health needs which differ from both younger children and older adults who need palliative care.

These include advance care planning (ACP) and end of life planning. Young people should have plans in place where it is unclear whether their condition will stabilise, deteriorate or enter the end of life phase; this is known as 'parallel planning'.

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[44] Commissioning for smooth transitions and age-appropriate care for young people with life-limiting conditions in England A guide for Clinical Commissioning Groups. Together for short lives
[45] Marie Curie Cancer Care and Together for Short Lives (2012). Don't let me down: ensuring a good transition for young people with palliative care needs

Although this strategy is for adults, services must take into account the needs of children transitioning into adult services to ensure they are prepared to manage the complex needs of these young people.

Local Commissioners and providers of Palliative and End of life for young adults care should work collaboratively and in an integrated manner to ensure processes enable a smooth transition taking into account the parallel planning process and ensuring alignment with the advanced care planning process adopted in adult care.

It is essential that the 'care coordinator' role is implemented at the very beginning of the transition phase to ensure relationship building commences prior to transfer.
The Transition Taskforce has conceptualised the way that the five key agencies should work together as a 'pentagon of support'

This pentagon is underpinned by health and social care working closely together to provide a foundation for all the other provision, with work, leisure and education being the two 'enabling agencies' on either side and independent living as the 'capstone' at the top.

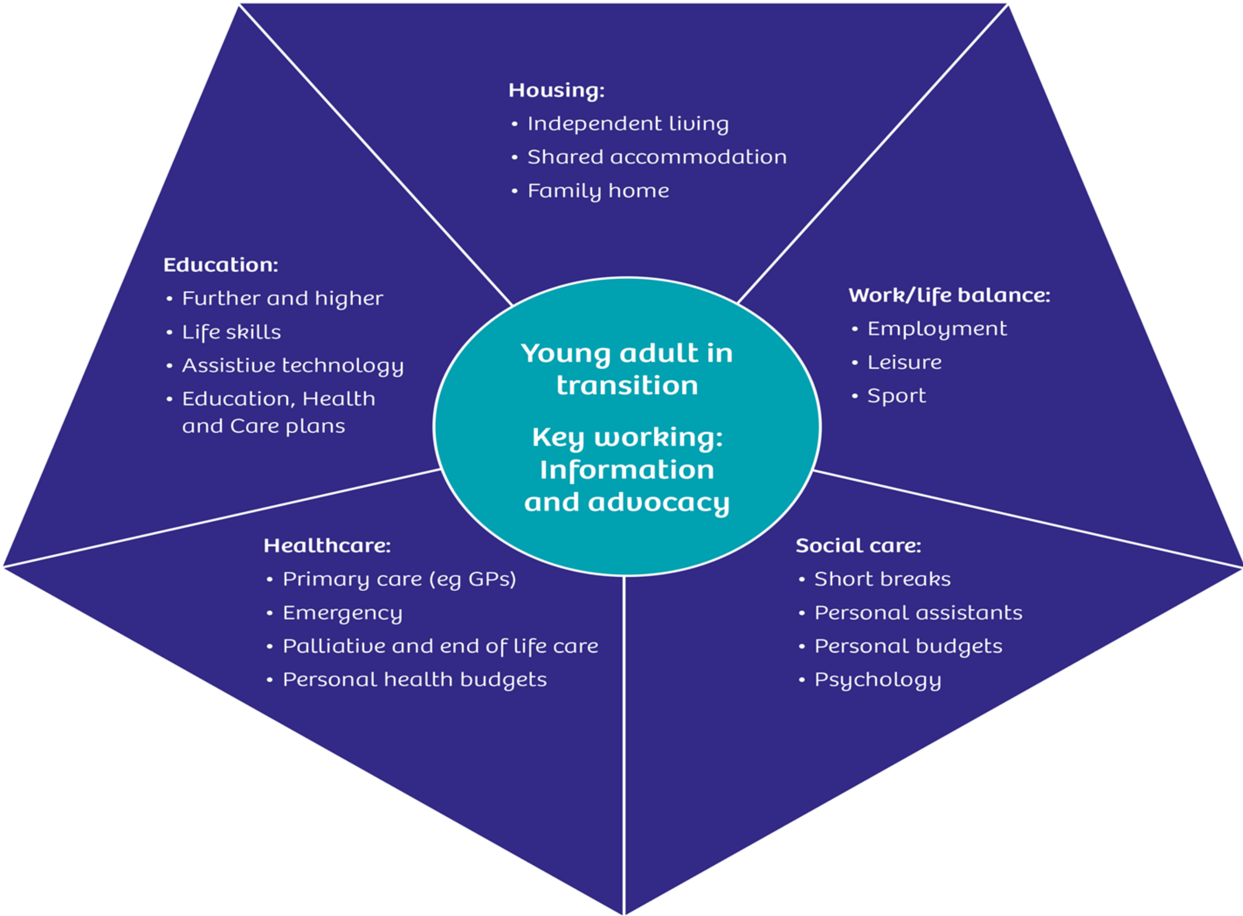


Figure 4 Pentagon of Support

All services must work together to ensure the successful transition to adult services.

6. **Patient and Carer Experiences of Current Services**

"I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s).[46]

For some, this is an apt description of how the system provides for them. For too many, it just doesn't match their experience. This should and does frustrate us. Our goal is to make this experience a consistent reality for all.

NHS England in its publication Actions for End of Life Care: 2014-16 states:
"The 2008 Strategy managed to reverse the upward trend of people dying in hospital. We now need to ensure that living and dying well is the focus of end of life care, wherever it occurs. This is the challenge: together we can and must achieve it." [47]

Most people (63%) would prefer to die in their own home, and just under a third would prefer to die in a hospice[48].

Locally, we have been gathering the experience and opinions of current End of Life care services in a range of different ways.

This evidence can be summarised by the following points:

The following are excerpts from engagement sessions across Wolverhampton.

Communication

68% of carers felt that teams didn't work or communicate with each other,
80% of them said they had to repeat information between 3-5 times, during the last few weeks of life to teams of professionals, here are some of their comments

"Lack of cohesive communication, repetition to several parties who should have known the information "

"There didn't appear to be the communication amongst the hospital teams. The district nurses, GP and Palliative Specialist nurse was very good"

"GP did not show any real concern or compassion"
"I don't feel there was enough communication."

[46] 23National Voices and The National Council for Palliative Care (NCPC) and NHS England (2015). Every Moment Counts: A narrative for person centred coordinated care for people near the end of life
[47] NHSE Actions for End of Life Care 2014-2016
[48] Macmillan Rich Picture on End of Life care

Care Planning

With the exception of one, all patients were referred to the palliative care team in the last few weeks, but only 31 % patients had a written care plan (ACP) (44% didn't and 19% weren't sure) of those who had a written plan, in 60% of these cases the plans was discussed with both patient and family.

Carers

100% of carers felt they were supported in the last 3 days of life, with regard to Hygiene, toileting, personal care and support to stay where they wanted to be, however 80% felt they didn't have enough spiritual support and 67% expressed they didn't feel they had enough emotional support.
All carers felt the family as a whole were supported at the time of death, however 83% of carers expressed that they wanted to have someone to talk to after their loved ones death

Co-Production

The underpinning ethos of this Strategy is ‘co-design’ which reflects the values of the Commissioners and Stakeholders involved in its development.
The ‘patient voice’ is at the heart of it, and patients are the additional partner in the Strategic vision for End of Life care provision.

Numerous national reports detail stories of patients and carers whom have experienced less than adequate care and support from End of Life care services and have expressed their desires and wishes for improvement in care at this distressing time.

Providers of care, both health and social care, express concerns regarding the current level of constraints, both financial and time to care.

To ensure that this Strategy goes someway to ensuring that all Partners are invited to have an equal voice in the development of this document, all partners have been invited to input into its development and will be actively involved in its implementation.

Partners also recognise that to deliver the outcomes, integrated services are key and to that end partnerships have been developed relationships with the following:

- primary care providers, to ensure a clinical focus and to understand the impact upon the current workforce to deliver improved end of life care; and
- Local Authority Public Health, to ensure the Strategy addresses the local variances, health and social care inequalities and to understand and develop realistic targets for the outcomes.

7. Glossary

ACP	Advanced Care Plan
CQC	Care Quality Commission
CCG	Clinical Commissioning Group
Co-design	Co-design Means designing, implementing and reviewing service redesign with patients and carers as equal partners.
DNAR	Do Not Attempt Resuscitation
DH	Department of Health
EoLc	End of Life care
EPaCCS	Electronic Palliative Care Coordination System
EoLc pathway	means the standardised step by step framework for all health and social care professionals working with patients who are nearing the end of their lives.
Healthwatch	means the consumer champion for health and social care.
Health & Wellbeing Strategy	A joint strategy between health & social care to improve the health & wellbeing of the population of Wolverhampton
HEE	Health Education England
Hub	A place where care is coordinated
JSNA	Joint Strategic Needs Assessment
LETb	Local Education Training Boards
MDT	Multi Disciplinary Team
NICE	National Institute for clinical Excellence
RWT	Royal Wolverhampton Hospitals

Wolverhampton End of Life care Population Profile

1. Population of Wolverhampton

This needs analysis covers both the registered and resident population of Wolverhampton.
The registered population figures are based on data collected on a quarterly basis and are a snapshot of the population of Wolverhampton at a particular date. It is not generally used to predict or project future population figures.

Resident population figures are based on the most recent census data (2011 Census) which is then used by the Office of National Statistics to generate "projected" or predicted populations for Wolverhampton for specific years.

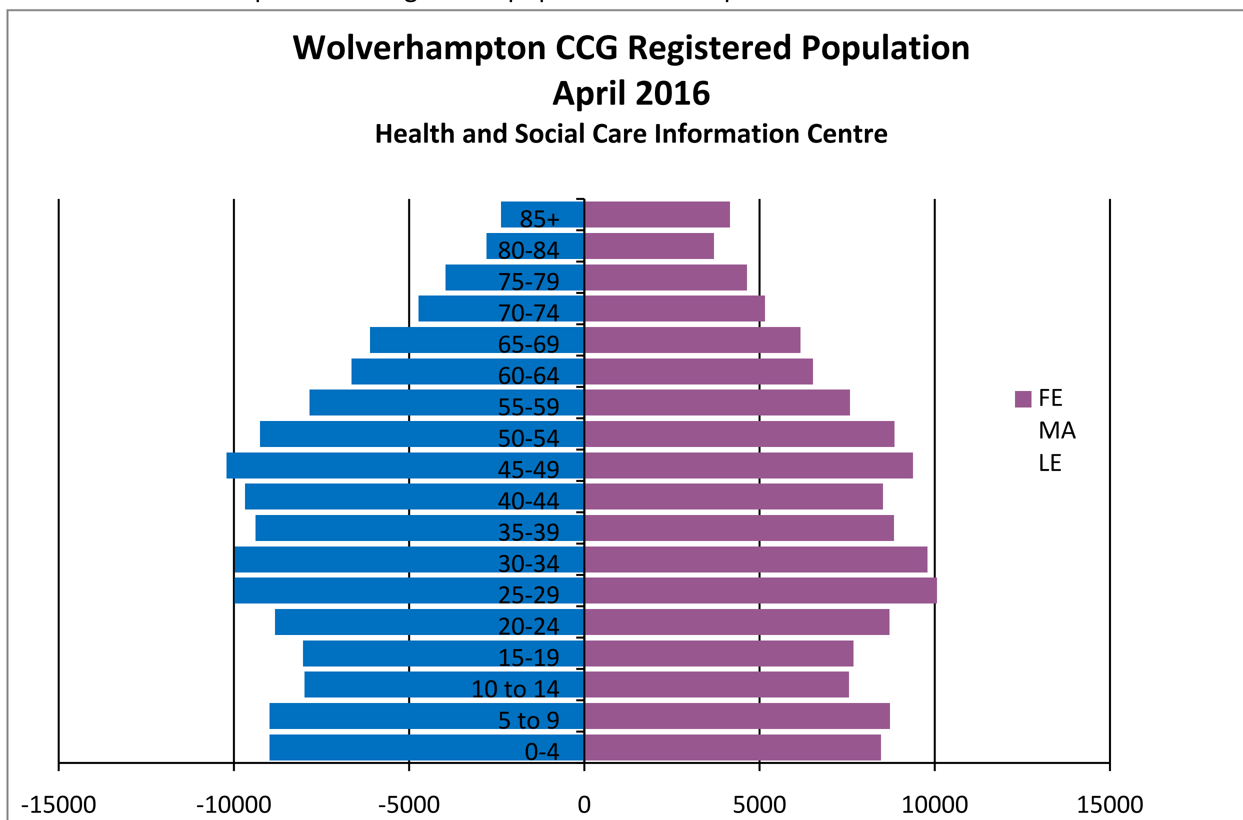
1.1 Local Population

Table 1 : Wolverhampton CCG **Registered population** as at April 2016

Age Band	Male	Female	Total
0-4	8,988	8,464	**17,452**
5 to 9	8,989	8,722	**17,711**
10 to 14	7,981	7,548	**15,529**
15-19	8,032	7,671	**15,703**
20-24	8,823	8,707	**17,530**
25-29	9,982	10,066	**20,048**
30-34	9,968	9,784	**19,752**
35-39	9,384	8,832	**18,216**
40-44	9,688	8,515	**18,203**
45-49	10,213	9,371	**19,584**
50-54	9,246	8,845	**18,091**
55-59	7,836	7,575	**15,411**
60-64	6,638	6,518	**13,156**
65-69	6,119	6,172	**12,291**
70-74	4,730	5,157	**9,887**
75-79	3,964	4,632	**8,596**
80-84	2,788	3,700	**6,488**
85+	2,373	4,151	**6,524**

(source – Health & Social Care Information Centre)

Chart 1 : Wolverhampton CCG Registered population as at April 2016



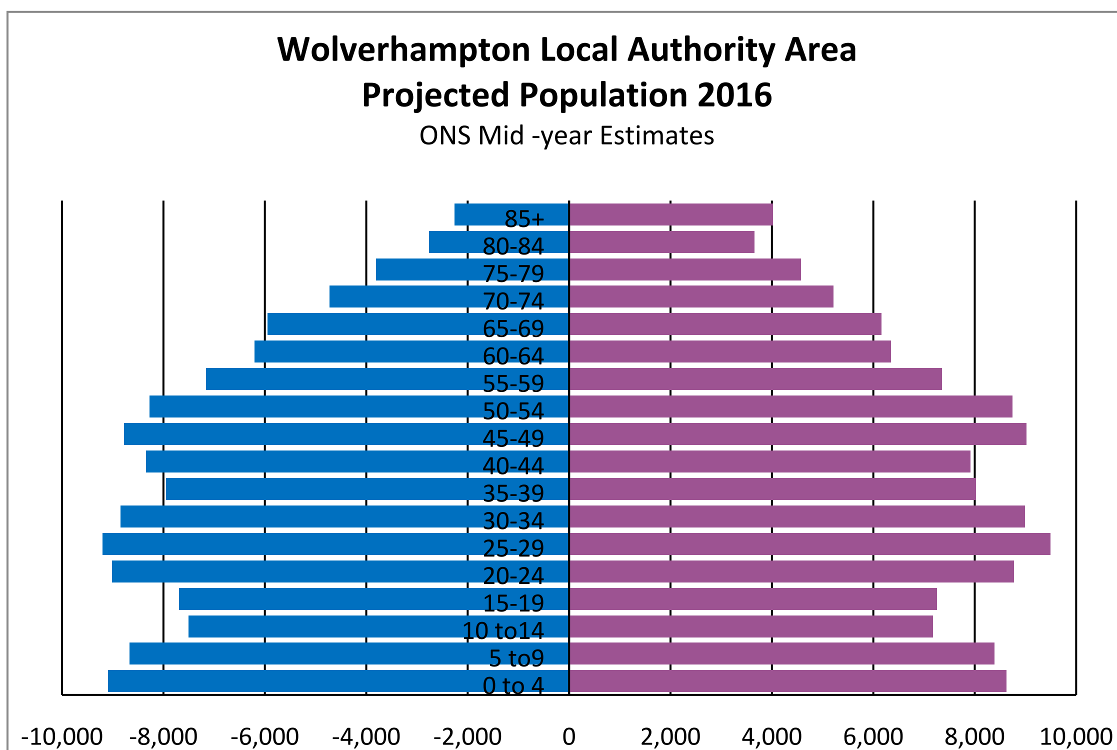
Source : Health and Social care information Centre July 2016

Table 2: Projected resident population of Wolverhampton 2016

Age Band	Male	Female	Total
0-4	9,093	8,625	**17,719**
5 to 9	8,663	8,387	**17,051**
10 to 14	7,505	7,171	**14,676**
15-19	7,695	7,254	**14,950**
20-24	9,008	8,773	**17,781**
25-29	9,203	9,494	**18,698**
30-34	8,843	8,989	**17,832**
35-39	7,949	8,025	**15,975**
40-44	8,343	7,916	**16,260**
45-49	8,770	9,020	**17,790**
50-54	8,275	8,743	**17,018**
55-59	7,153	7,354	**14,507**
60-64	6,199	6,341	**12,541**
65-69	5,949	6,158	**12,107**
70-74	4,721	5,215	**9,936**
75-79	3,806	4,570	**8,377**
80-84	2,762	3,652	**6,415**
85+	2,255	4,018	**6,274**

(source : Office for National Statistics Mid-Year Estimates 2016)

Chart 2 : Projected resident population of Wolverhampton 2016



(source : Office for National Statistics(ONS) Mid-Year Estimates 2016)

There are some relatively minor differences between the two sets of data – the number of patients of both sexes aged 65 and above registered with Wolverhampton GPs is slightly higher than the number projected by ONS, but this difference is less than 2% of the total in that age group.

1.2 Older Population of Wolverhampton

1.2.1 Over 65 Population of Wolverhampton by Wards

The chart below shows where the highest percentages of older people (those aged 65 and over) live across the various council wards. This information is taken from the 2011 census but the overall pattern is expected to be similar.

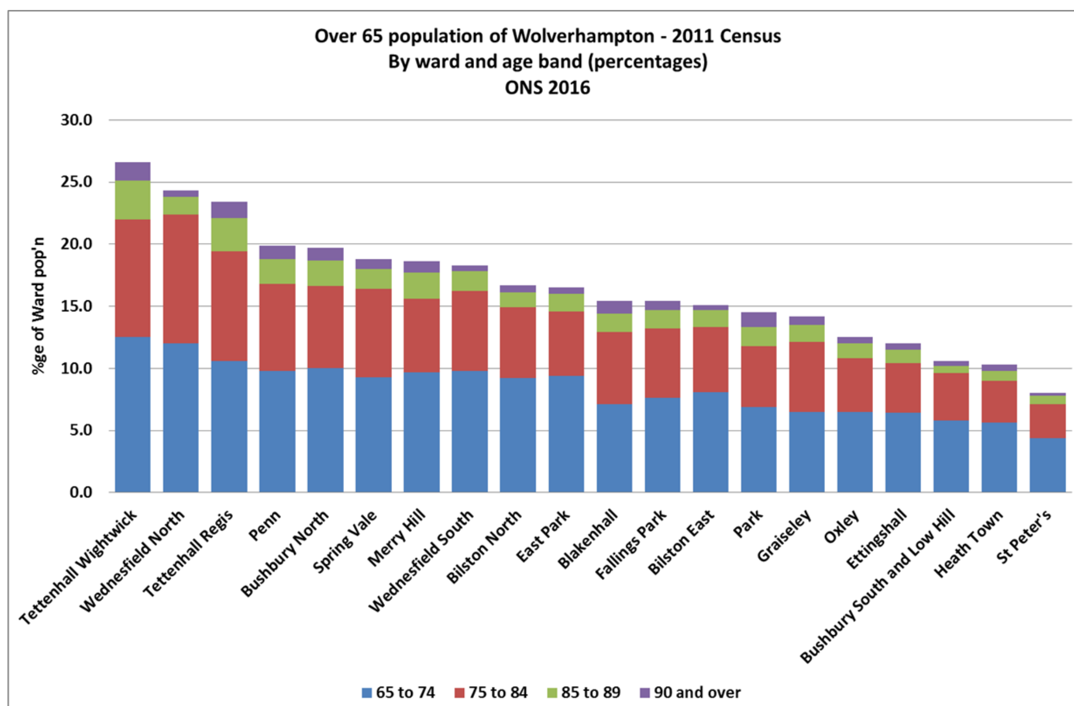


Chart 3 –Source : ONS 2016

1.2.2 Projected resident population of Wolverhampton aged 65 and over for 2021 and 2026

The tables below indicate the projected change in the number of people in the 65yrs and over population of Wolverhampton for 2021 and 2026 from those projected for 2016. The vast majority of deaths in 2014 (79% of men and 86% of women, 82% overall) were in the over 65yrs age group, so it is likely that any increases in that population would lead to an increase in the numbers requiring end of life care. This information is not available at council ward level so local changes cannot be calculated.

The projected changes between 2016 and 2021 are not particularly large, with an overall increase of only 5% in the over 65yrs population as a whole. However, one of the largest increases are predicted to be in the 85yrs and over population, which has made up about a third of all deaths for the past 10 years.

Table 3 : Projected changes in the population of Wolverhampton aged 65 and over

	2016-2021			2016-2026		
	Male	Female	Total	Male	Female	Total
65-69	-250	-193	**-443**	237	490	**727**
70-74	628	531	**1,159**	441	368	**809**
75-79	270	134	**404**	887	662	**1,549**
80-84	239	143	**382**	549	343	**892**
85 and over	394	287	**681**	915	768	**1,683**

(Source ONS 2016)

Table 4 : Projected percentage changes in the population of Wolverhampton aged 65 and over

	2016-2021			2016-2026		
	Male	Female	Total	Male	Female	Total
65-69	**-4**	**-3**	**-4**	**4**	**8**	**6**
70-74	**13**	**10**	**12**	**9**	**7**	**8**
75-79	**7**	**3**	**5**	**23**	**14**	**18**
80-84	**9**	**4**	**6**	**20**	**9**	**14**
85 and over	**17**	**7**	**11**	**41**	**19**	**27**
Total	**7**	**4**	**5**	**16**	**11**	**13**

Source : ONS 2016

1.3 Ethnicity in Wolverhampton

According to the 2011 census, which is the most recent reliable data available, almost a third of Wolverhampton's population (32%) was from black and minority ethnic groups.

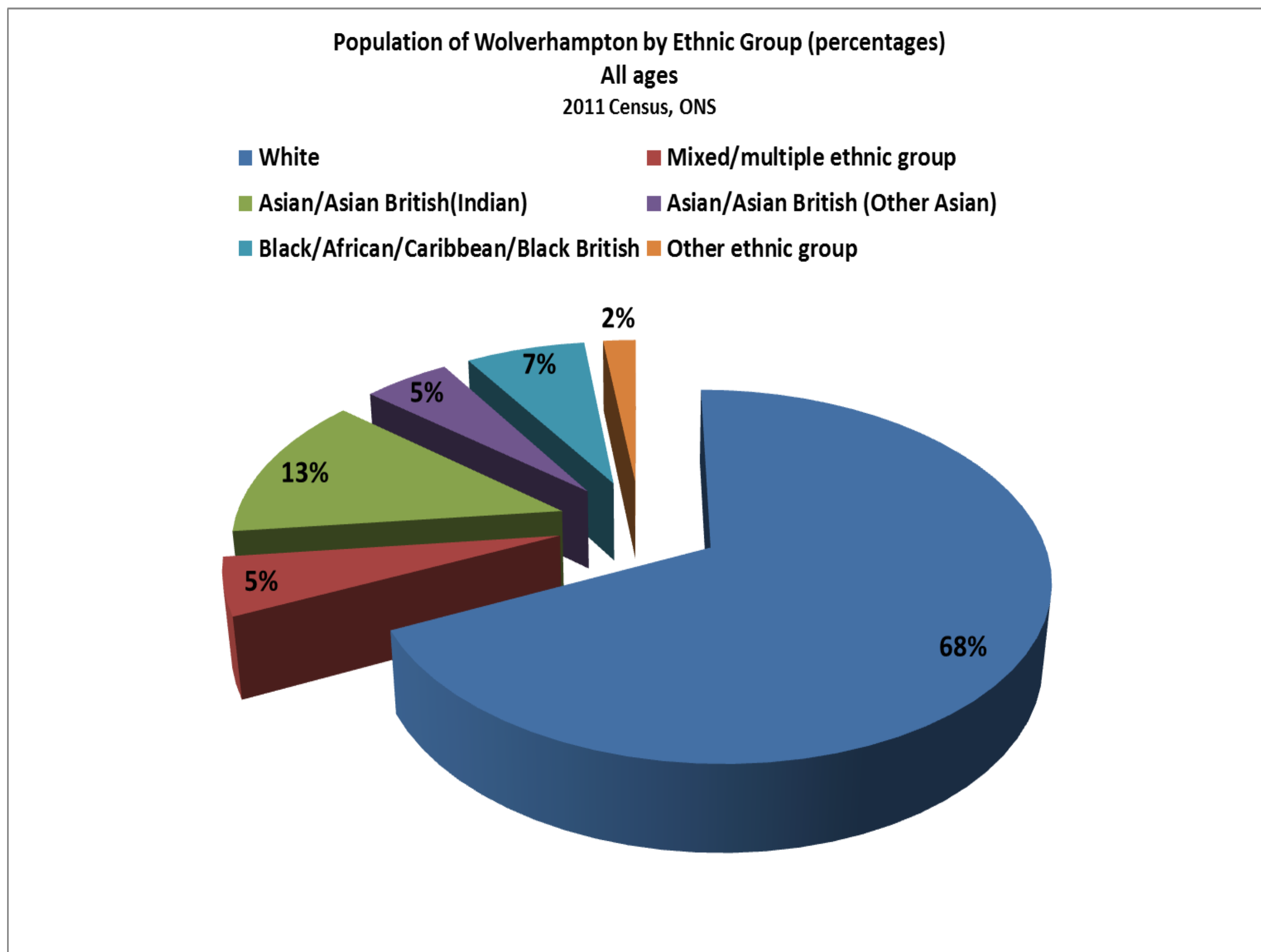
Table 5 : Population of Wolverhampton by Ethnic Group (percentages)

White	68
Mixed/multiple ethnic group	5
Asian/Asian British	18
Black/African/Caribbean/Black British	7
Other ethnic group: Any other ethnic group	2

Source : ONS 2016

If you analyse the above figures in more detail, it is notable that a significant majority (71%) of the Asian population identifies as "Indian" in ethnic origin.

Chart 4



Source: ONS 2016

There are a number of significant differences in the ethnic makeup of the population of Wolverhampton. There are distinct differences between age groups within the population.

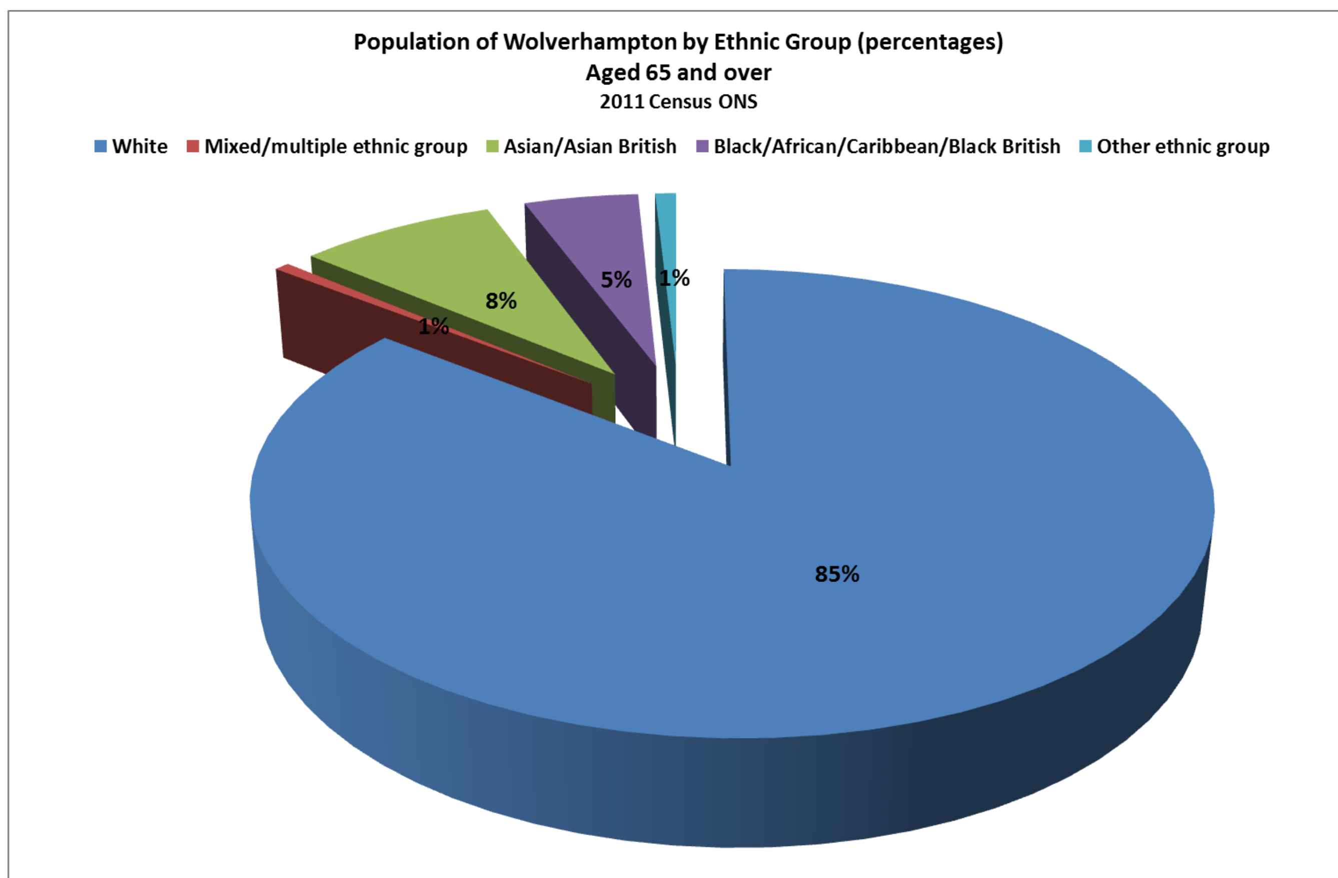
Table 6 and Chart 5 below give the ethnic breakdown for the population aged 65 and over :

Table 6 **:** Population of Wolverhampton aged 65 and over by Ethnic Group (percentages), 2011 Census

White	86
Mixed/multiple ethnic group	1
Asian/Asian British	8
Black/African/Caribbean/Black British	5
Other ethnic group: Any other ethnic group	1

Source : ONS 2016

Chart 5



Source ONS 2016

It is noticeable that the over 65 population reported in the 2011 census is much less ethnically diverse than the population as a whole, and the percentage of people from black and minority ethnic communities reduces further in the oldest age groups as the table below shows.

Table 7: Population of Wolverhampton by Ethnic Group and Age Group (Percentages)
2011 Census

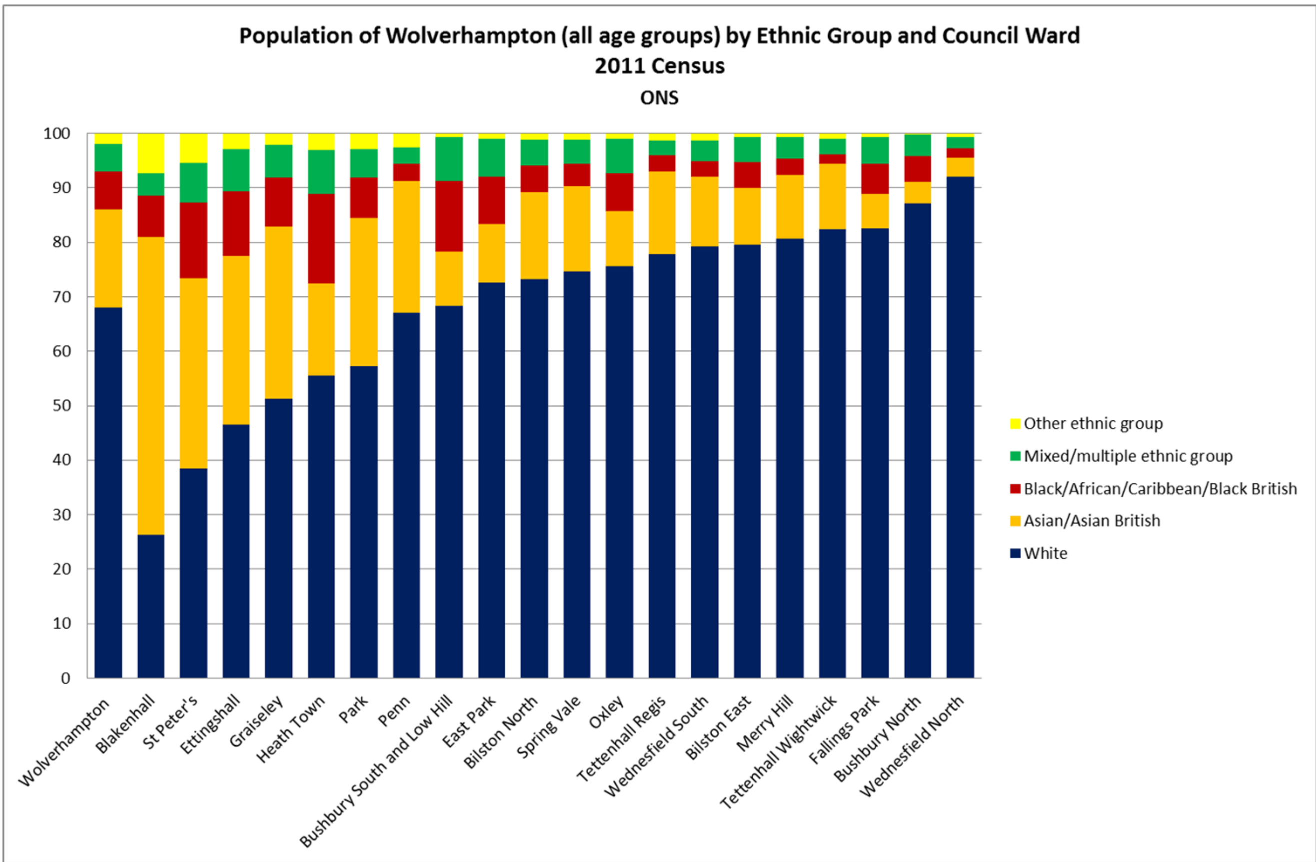
Ethnic Group	70-74	75-79	80-84	85+
White	83	84	87	91
Asian/Asian British	10	9	5	4
Black/African/Caribbean/Black British	5	6	5	3
Any other ethnic group	2	1	2	2

Source: ONS 2016

In all the age groups across the population, the largest proportion of people from Black and Minority Ethnic Groups identify as Indian in ethnic origin, but in the older age groups there is an almost equal percentage of people from the Black Caribbean ethnic group.

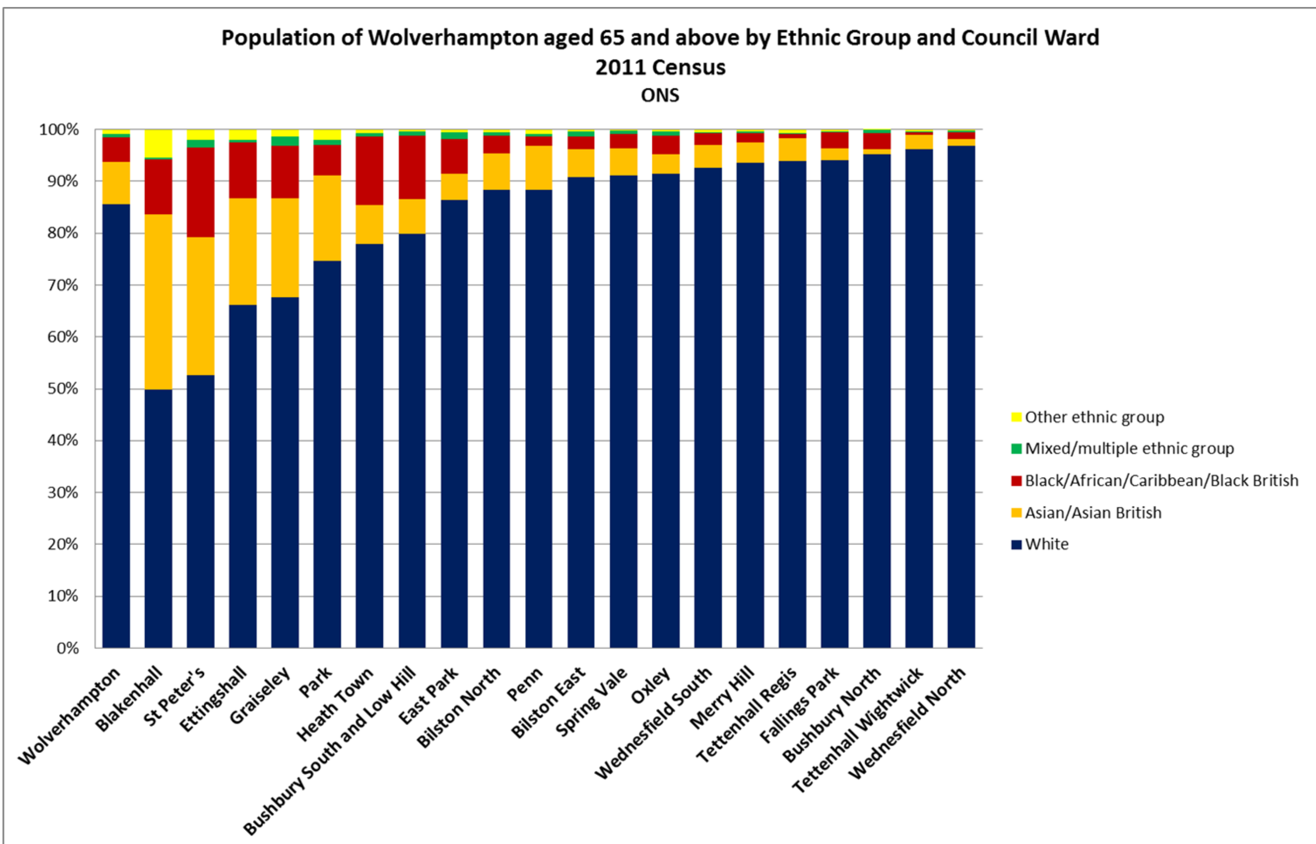
In addition to differences between age groups, there are also quite significant geographical differences in the ethnic makeup of the population. The city's minority ethnic communities are concentrated in a relatively small number of areas, as the charts below indicate. Both charts show the breakdown of population by ethnic community in each of the City Council's electoral wards. The first (Chart 5) shows the breakdown of the population as a whole, the second (Chart 6) shows the same breakdown for those aged 65 and over, which is the age group in which death is most likely to occur.

Chart 6



Source : ONS 2016

Chart 7



Source : ONS 2016

1.4 Faith and Religion in Wolverhampton

A person's religion, faith and spirituality can be very important to them when they are approaching the end of their life.

Different faiths and belief systems have different attitudes to death and dying,.

There will be different ways of managing bereavement and different rituals following someone's death and these attitudes and approaches can have quite a significant impact on how peoples choices at end of life. –It is important that end of life care services are provided in a way that is culturally appropriate, that recognises differences arising from different faiths and that they are accessible to those of all faiths.

The table and chart below show the stated faiths / religions of the population of Wolverhampton according to the 2011 Census.

This mirrors to some extent the ethnic makeup of the city, with the majority of the Asian population also being Sikh.

A small minority (less than 1%) stated a belief in Buddhism or the Jewish faith. These have been omitted.

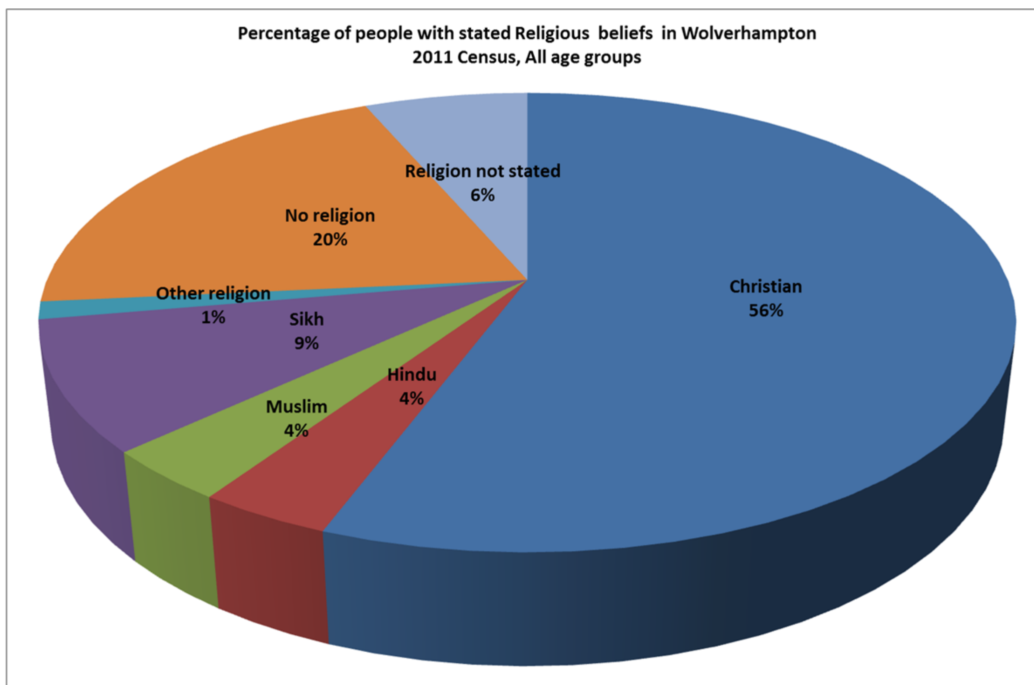
Percentage stated Religion/ Faith within the population of Wolverhampton

Table 8 : Stated Religion in Wolverhampton 2011 Census, All age groups

Christian	Hindu	Muslim	Sikh	Other religion	No religion	Religion not stated
55	4	4	9	1	20	6

Source : ONS 2016

Chart 8



There are significant differences between the population as a whole and the older population of Wolverhampton.

The chart and table below show the same breakdown for the ver 65yrs population.

The percentage of people stating they had no religion is very much lower, as is the percentage of people with religions other than Christianity.

This shows an increase of 24% compared with the population as a whole.

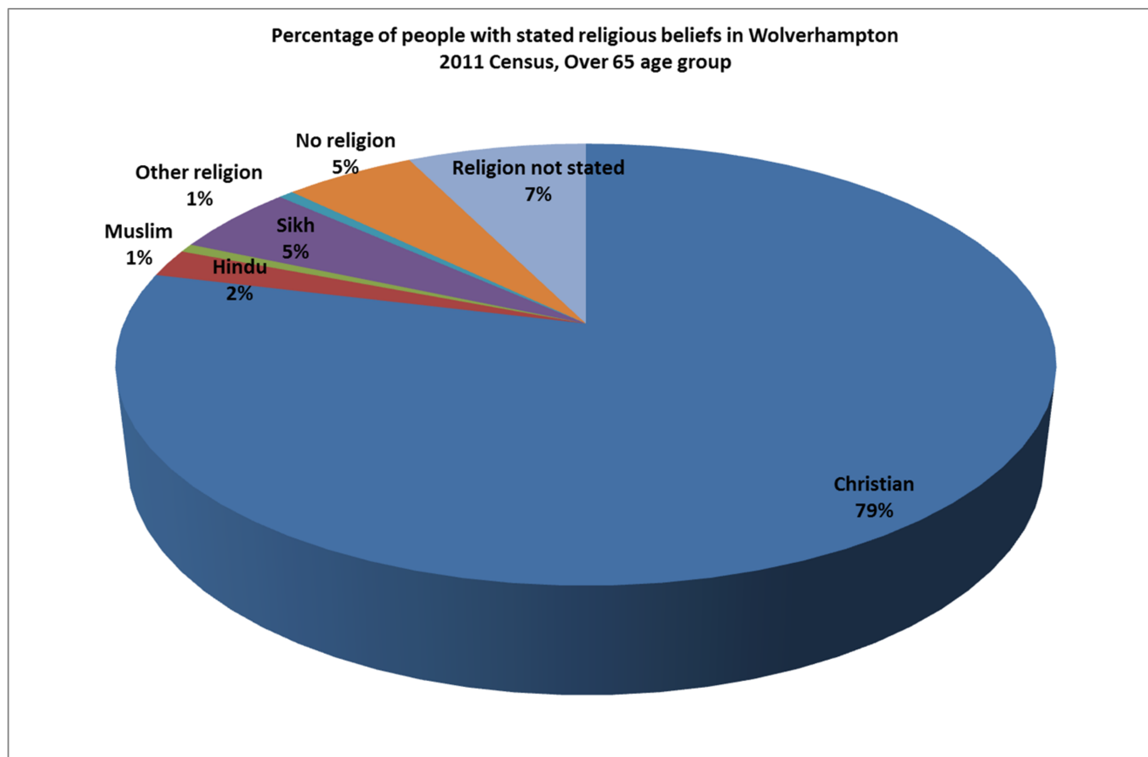
This data requires recognition in the commissioning and provision of multi cultural end of life care services.

Table 9 : Percentage stated Religion/ Faith within the population of Wolverhampton
Over 65 age group, 2011 Census,

Christian	Hindu	Muslim	Sikh	Other religion	No religion	Religion not stated
79	2	1	5	1	5	7

Source : ONS 2016

Chart 9:



Source: ONS 2016

2. Deaths in Wolverhampton

Information on Deaths in Wolverhampton is taken from Public Health England's End of Life Intelligence Network. This provides information on the number of deaths, place and cause of death, broken down by age groups.
The analysis – tables and charts – that follow are based on the data available to Clinical Commissioning Groupss. More detailed analysis of this data could be provided by Wolverhampton's Public Health Directorate if required.

It has not been possible to identify whether there are any significant differences in the age profile, place or cause of death between the male and female population of Wolverhampton, or whether the trends and patterns in the overall population are reflected in the two sexes.

2.1 Number of deaths

The table and chart below show the number of reported deaths in Wolverhampton for the years 2004-2014, which is the most recent data available.

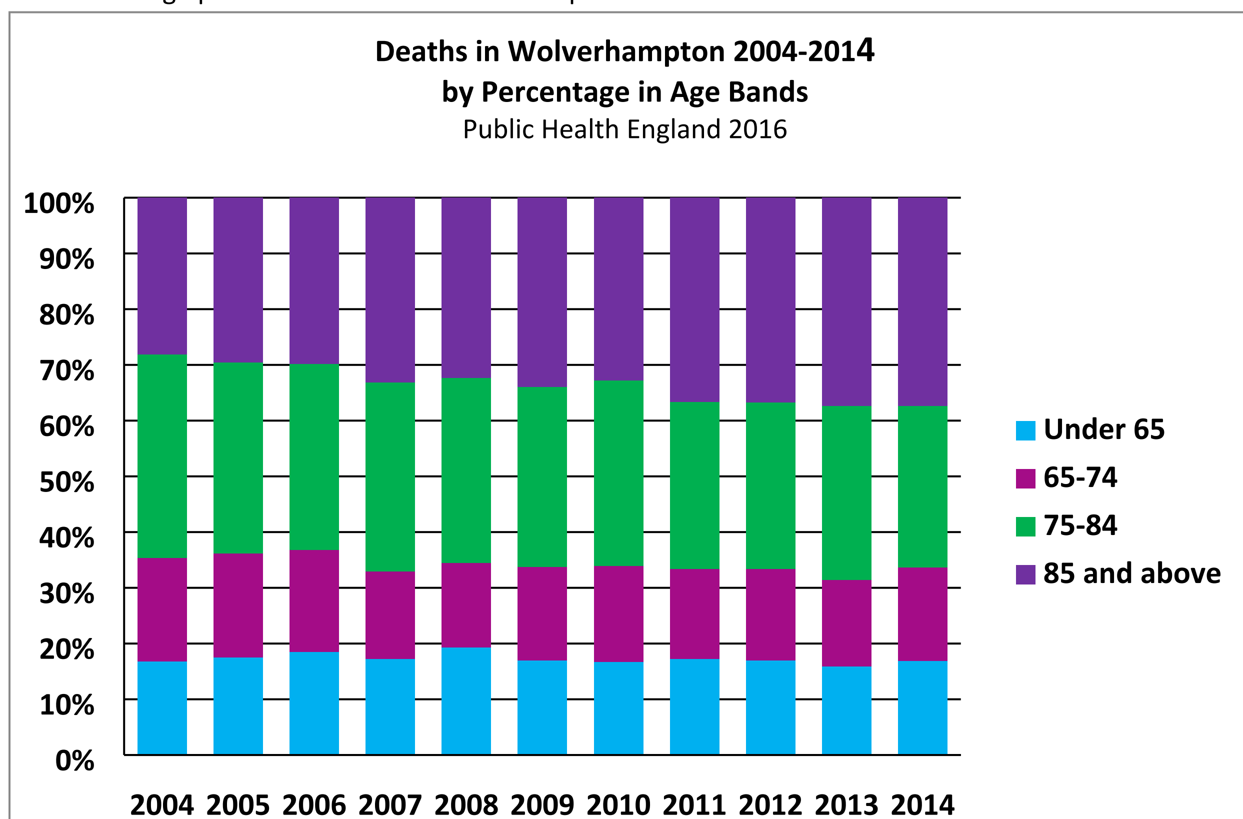
Table 10 - Number of deaths in Wolverhampton 2004-2014 by age group -

Age Band	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
<65	424	451	476	430	479	403	411	401	404	391	412
65-74	469	478	472	389	376	397	422	375	388	383	406
75-84	919	881	859	843	822	765	818	694	709	766	704
85+	709	759	767	825	803	805	804	852	873	920	909

TOTAL	2521	2569	2574	2487	2480	2370	2455	2322	2374	2460	2431

Source : Public Health England (PHE) 2016

Chart 10 – Age profile of deaths in Wolverhampton 2004-2014.



Source : PHE 2016

2.1.1 Estimating death rates in different age groups

The table below uses the projected mid-year population for Wolverhampton for 2014 and the reported deaths in Wolverhampton in 2014 (which is the latest data available) to calculate the estimated percentage of deaths in each age group of the population.

As the table shows, the overall percentage death rate for Wolverhampton in 2014 was 0.96% which is very close to the national estimated rate of 1%.

Table 11

Death rate for age groups in Wolverhampton based on 2014 figures.

Number of recorded deaths in Wolverhampton

	Projected Population	Reported Deaths	%ge of people who died in age group
under 65	210,614	412	0.20
65-74	21,527	406	1.89
75-84	14,801	704	4.76
85 and above	6,045	909	15.04
All ages	**252,987**	**2,431**	**0.96**

Source : Calculated from PHE and ONS data

As expected, the death rate increases with older age

2.1.2 Estimating the predicted number of deaths in future years

The estimated rates of death in each age group could be used, in conjunction with published population projections, to estimate the likely number of deaths in any given year.
The table below shows the above percentage death rates applied to the projected population of Wolverhampton for 2021 and 2026 to estimate the number of deaths in each age group in those years.

Table 12: Estimated number of deaths in Wolverhampton 2021 and 2026
By age group, based on 2014 estimated death rates and ONS projected populations

	2021	**2026**
under 65	426	433
65-74	429	445
75-84	741	820
85 and over	1,046	1,197
TOTAL	**2,642**	**2,894**

Source: Calculated from PHE and ONS data

The percentage increase in deaths across all age groups is about 9% for 2021 and about 19% for 2026 – but the individual age groups show a wide variation in percentage increases.

The table below shows the estimated numbers and percentage increases for each age group for 2021 and 2026 compared with the 2014 figures.

Table 13: Estimated number and percentage increases in deaths by age group

	2021		**2026**	
under 65	14	3%	21	5%
65-74	23	6%	39	10%
75-84	37	5%	116	16%
85 and above	137	15%	288	32%
All ages	211	9%	463	19%

Source : Calculated from PHE and ONS data

These figures suggest that there may be a significant increase in need for end of life support.

2.2 Place of death

This is another important measure of the quality of end of life care.
The number of people who have died in their own home (or usual place of residence) is seen as a good indicator of people receiving choice at end of life.
There are two alternative measures – one provides data on places of death – Home, Hospital, Care Home, Hospice and Other.
The second provides data on deaths in what is described as someone's "Usual Place of Residence" (DIUPR) which includes both people's own homes and care homes.
The data on deaths used to produce these statistics is slightly different, so the number of deaths can't be directly compared – although the percentages are very similar for both sets of data.

Table 14
Percentage of deaths in Wolverhampton 2004-2014 by place of death – all age groups

	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Hospital	62	63	63	59	59	57	60	57	56	56	55
Home	18	18	18	19	19	20	20	23	22	21	22
Care Home	13	14	13	16	16	17	15	16	16	17	16
Hospice	4	4	5	4	5	4	3	2	5	4	5

Other	2	1	2	2	2	2	2	2	2	1	2

Source: PHE 2016

Table 15

Percentage of deaths in Wolverhampton reported to be in "Usual Place of Residence" – all age groups

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
DIUPR	32	31	30	35	35	37	36	39	38	39	38

Source: PHE 2016

Analysing these figures in more detail, there are different patterns across different age groups. For example, the percentages of people who die aged over 85yrs in the various places identified is different from those in other age groups.
The table and chart below show these different percentages for the most recent year, 2014.

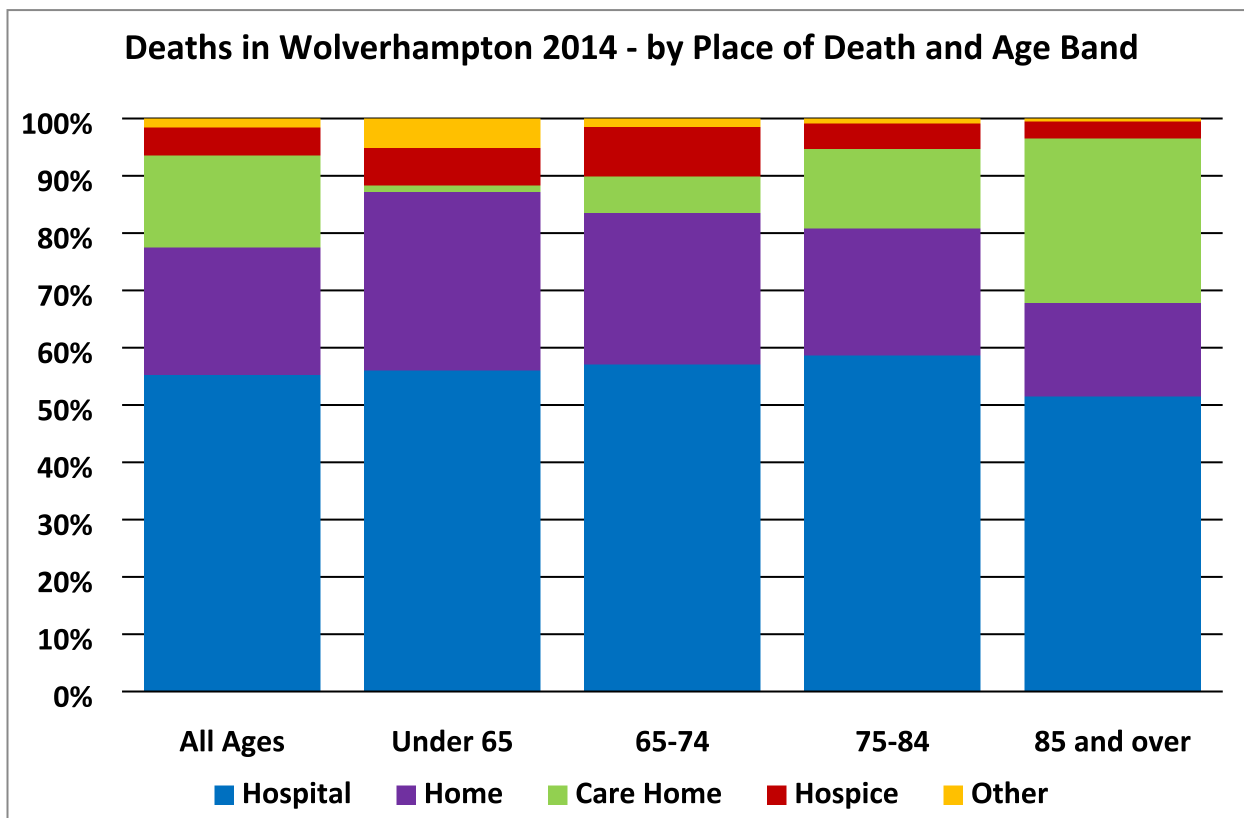
Table 16

Percentage of deaths in Wolverhampton 2014 by place of death and age band

	All Ages	Under 65	65-74	75-84	85 and over
Hospital	55	56	57	59	51
Home	22	31	26	22	16
Care Home	16	1	6	14	29
Hospice	5	7	9	4	3
Other	2	5	1	1	0

Source: PHE 2016

Chart 11



Source: PHE 2016

2.3 Changes in place of death over time

2.3.1 Previous 10 years :

Over the 10 year period between 2004 and 2014 there have been some changes in where people in Wolverhampton end their lives.

There has been a consistent decrease in the percentage of people dying in hospital and an increase in those dying at home or in a care home, but there are some years where those overall trends are much less pronounced.

Here is a quick summary :

- 6.6% fewer people died in hospital
- 3.7% more people died at home
- 2.6% more people died in a care home
- 0.7 % more people died in a hospice.

This pattern of change differs between different age groups – the biggest reduction in deaths in hospital is in the 75-84 and 85 and above age groups, where the reduction was between 6.9% and 7.4%, while the reduction in younger age groups was much lower, around 4% overall.

The increase in deaths at home was greatest in the 75-84 age group (6.7%) and in the under 65 age group (6.1%) while the increase in over 85 age group was much smaller (3%) and there was very little increase (0.1%) for the 65-74 age group. Those figures are balanced to some extent by the increase in deaths in care homes in the 85 and over age group (2.9%) .

2.3.2 Previous 5 years

Over the 5 years between 2009 and 2014 the changes in place of death were slightly different.

There was an overall increase of 2% in deaths at home, and an equivalent reduction in deaths in hospital, but the scale of change was generally much smaller across age groups.

The biggest change was an increase of nearly 5% in the percentage of people aged 85 and over dying at home, together with almost 3% reductions in the percentage of the same age group dying in a care home or in hospital.

2.3.3 Previous 2 years :

Over the most recent two years (2013-2014) there was little or no change in the overall percentages of people dying in hospital or at home. There was actually an increase in the percentages of those aged 65 -74 and 75-84 dying in hospital and a reduction in those in the same age groups dying at home, but this was matched by a much bigger reduction in the percentage of deaths in hospital among the 85 and over age group, together with increases in those dying at home or in a care home.

2.4 Causes of death

The statistics produced by Public Health England allow some analysis by cause of death – however, this is limited to 4 disease areas – Cancer, Circulatory, Respiratory and, by exclusion, Other.

While these causes of death are recognised as the most frequent causes of death in Wolverhampton, and equally elsewhere in the UK, the data available does not identify anything beyond the direct cause of death and does not indicate whether people had any Life-Limiting Long Term conditions that may have contributed to their death.

The table and chart below shows the percentage of each cause of death in Wolverhampton across all age groups between the years 2004 and 2014.

Table 17:

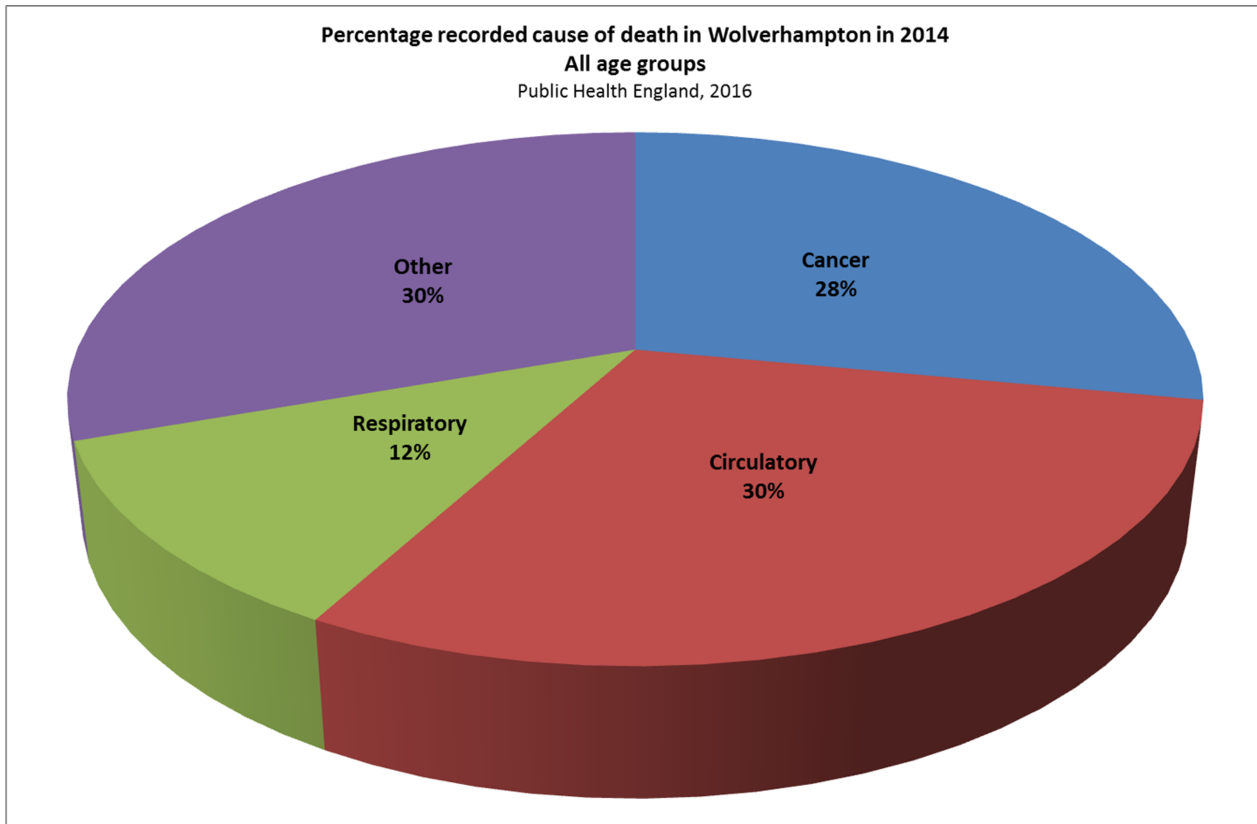
Percentage recorded Cause of Death in Wolverhampton, all age groups 2004-2014

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Cancer	25	25	27	26	26	28	27	28	27	29	28
Circulatory	37	34	33	34	32	32	34	29	29	26	30

Respiratory	14	14	13	13	14	13	15	14	15	14	12
Other	25	26	27	27	28	27	25	30	29	32	30

Source PHE 2016

Chart 12



Source : PHE 2016

As with many other statistics, the recorded causes of death differ across different age groups. The table below shows these differences for deaths reported in Wolverhampton in 2014.

Table 18: Percentage recorded Cause of Death in Wolverhampton in 2014, by age group

	All ages	under 65	65-74	75-84	85 and above
Cancer	28	34	45	27	18
Circulatory	30	23	26	34	32
Respiratory	12	7	9	13	13
Other	30	36	19	25	37

Source : PHE, 2016

Analysing this data reveals the following trends,:

- The percentages of deaths from circulatory conditions increases in the older population groups.
- The percentages of deaths from respiratory conditions increases in the older population groups
- The percentage of deaths from cancer reduce significantly in the older population groups.

It is significant that the percentages of deaths from "Other" causes is highest in the under 65 and over 85 populations, and makes up the largest percentage of deaths in both these age groups, but without more detailed information it is not possible to explain what underlies these figures.

2.4.1 Causes of death from 2004-2014

During the period 2004-2014, there have been some changes in the causes of death in the population of Wolverhampton. Although there are variations from year to year, there are some general trends that can be identified **:**

- An increase in the percentage of people dying from cancer
- A decrease in the percentage of people dying from circulatory problems
- An increase in the percentage of people dying from "other" causes
- No real change in the percentage of people dying from respiratory problems

Looking at the trends in causes of death across different age groups, there have been the following changes in percentages over the 10 years:

- Cancer
  - No significant change for the under 65 age group
  - A slight increase for the 65-74 and 75-84 age groups
  - A more significant increase for the 85 and over age group
- Circulatory problems
  - A reduction for the under 65, 65-74 and 75-84 age groups
  - A smaller reduction for the 85 and over age group
- Respiratory problems
  - An increase for the under 65 age group
  - An overall increase for the 65-74 age group, but a very significant reduction in the last few years
  - A slight reduction for the 75-84 and over 85 age groups

2.4.2 Causes of death and different age groups

An alternative way of looking at how different causes of death affect different age groups is to look in more detail at how each age group is represented (as a percentage) in the causes of death data and comparing that percentage with the proportion of deaths among that age group in the overall number of deaths.
For example, in 2014, 27% of the people who died of cancer were aged between 65 and 74, where that age group only made up 17% of deaths, but only 25% of deaths from cancer were people aged 85 and over, where that age group made up 37% of deaths in the year. The table below shows these comparisons for the four identified causes of death in the PHE data for 2014.

Table 19:

Causes of Death by Age group

Age Group	%ge of all deaths	Causes of Death			
		Cancer	**Respiratory**	**Circulatory**	**Other**
under 65	17	20	10	13	20
65-74	17	27	13	14	11
75-84	29	28	34	33	24
85 and over	37	25	43	40	45

Source : PHE 2016

This analysis shows that the older age groups are more heavily represented in deaths from Respiratory and Circulatory problems and in deaths from Other causes than would be predicted and that the younger age groups are much more heavily represented in deaths from Cancer.

3. Emergency admissions and deaths in Hospital

In Wolverhampton, a number of people are admitted to hospital in an emergency and die there after a relatively short stay, with no clinical intervention beyond treatment of their existing health needs.

The information available on this group of patients gives details of their ages, the amount of time they spent in hospital, the main condition they had on admission and their ethnicity, where that is recorded. The paragraphs, tables and charts that follow are based on the most recent information available, which covers the period from April 2014 up to and including March 2016.

3.1 Age and length of stay

In the two years from April 2014 to March 2016, over a thousand patients were identified as emergency admissions with very short lengths of stay before they died – about the same number (approx. 500) in each year. Of these, two thirds were aged 80 and over, and a further fifth were aged between 70 and 79, making a total of 85% aged 70 and over.

The table below shows the number of people in each age group analysed by the number of nights they were in hospital after admission.

Table 20: Length of stay in hospital – emergency admissions

	2014-15			**2015-16**			**TOTAL**
Age	**0-2 nights**	**3 to 7 nights**	**7 or more nights**	**0-2 nights**	**3 to 7 nights**	**7 or more nights**	
under 60	5	11	7	13	12	12	**60**
60-69	17	11	18	18	14	15	**93**
70-79	36	35	34	34	23	41	**203**
80 and over	83	117	145	99	97	148	**689**
Total	**141**	**174**	**204**	**164**	**146**	**216**	**1045**

Source: Midlands and Lancashire CSU, July 2016

Over the two years for which we have data, 29% of all patients were in hospital for 2 nights or less, 31% for between 3 and 7 nights and 40% for 7 nights or more before they died.

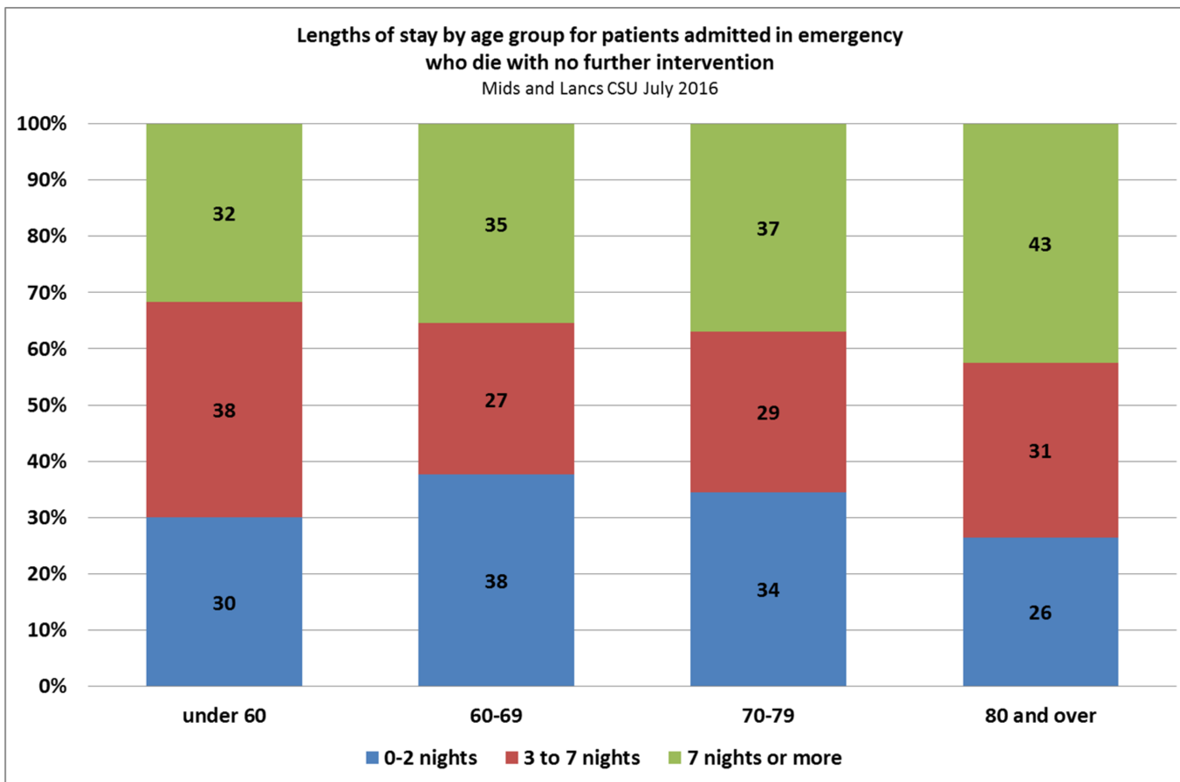
There are different percentages for each age group, as shown in the table and chart below.

Table 21: Percentages of each age group and length of hospital stay

	0-2 nights	**3 to 7 nights**	**7 or more nights**
under 60	30	38	32
60-69	38	27	35
70-79	34	29	37
80 and over	26	31	43
All ages	29	31	40

Source: Midlands and Lancashire CSU, July 2016

Chart 13 :



Source: Midlands and Lancashire CSU, July 2016

This indicates that the older groups of patients tend to be in hospital for slightly longer after admission before their death than the comparatively younger age groups.

3.2 Primary Diagnoses on admission

Each person in this group has a "primary diagnosis" which describes the main health problem that led to their admission in an emergency.
The patient group is defined as those who die "with no intervention" which means that they continue to be treated for their existing health needs, but that no "additional" intervention is carried out by the hospital.
There are nearly 200 individual "Primary Diagnoses" identified in the data, many of them only having one or two patients admitted over the two year period, but there are about 20 where there have been a significant number of admissions.

An analysis of the primary diagnoses using the four "Causes of Death" identified in the PHE data show the following :

- 43% are a result or Respiratory conditions
- 16% are a result of Circulatory conditions
- 10% are a result of Cancer in some form
- 32% are caused by "Other" causes

Of the respiratory conditions, the most common is pneumonia – in various forms – making up over 60% of the deaths.
Of the "Other" conditions, the most commonly identified is Urinary Tract Infection (UTI) which makes up 18% of the "Other" conditions with the second most common being Septicaemia (15%).

Looking at the primary diagnoses in the older age groups, there are no real differences between those for all ages and for those aged 70 and above. The most common condition among the respiratory problems is pneumonia, and the most common conditions in "other" are UTIs, Septicaemia and kidney disease.

3.3 Ethnicity among this patient group

An analysis of these patients by ethnic group (as recorded by the hospital) provided the following information.
The classifications used for ethnicity are not exactly the same as those used by the 2011 census, but it is still possible to identify whether certain ethnic groups are more heavily represented in this group of patients than they are in the wider population.

Table 22 : Recorded Ethnicity of patients admitted to hospital who die with no further intervention compared with percentages from 2011 Census (all ages)

<table>
<tr><th>Ethnic Group</th><th>Number of Px</th><th>%ge</th><th>%ge in 2011 Census (All ages)</th><th>%ge in 2011 Census (Over 65s)</th></tr>
<tr><td>White</td><td>877</td><td>84</td><td>68</td><td>85</td></tr>
<tr><td>Indian</td><td>65</td><td>6</td><td>13</td><td rowspan="2">8</td></tr>
<tr><td>Other Asian</td><td>8</td><td>1</td><td>5</td></tr>
<tr><td>Black Caribbean</td><td>41</td><td>4</td><td>7</td><td>5</td></tr>
<tr><td>Any other ethnic group</td><td>6</td><td>1</td><td>2</td><td>1</td></tr>
<tr><td>Mixed / multiple</td><td>N/A</td><td></td><td>5</td><td>1</td></tr>
<tr><td>Not stated / not known</td><td>48</td><td>5</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Total</td><td>1045</td><td colspan="2"></td><td></td></tr>
</table>

Source: Source: Midlands and Lancashire CSU, July 2016 and ONS 2016

If the percentage figures are compared with the all age population recorded in the 2011 census it would appear that the white ethnic group are significantly over-represented in this patient group.
It is, however important to note that over 90% of those in this patient group are aged 60 and above, and that the percentage of people recorded as being in the white ethnic groups in the 2011 Census increases quite significantly in the older age groups.
Using the 65 and over percentages from the 2011 Census (as shown in the same table) for the comparison indicates that there is a much closer correlation, with no real differences between the two sets of figures. .

4. Palliative Care Registers in primary care

Under the Quality and Outcome Framework (QOF) GP Practices are expected to keep a register of the number of patients who have been identified as needing palliative or end of life care, and to undertake multidisciplinary team (MDT) reviews of their care needs every 3 months.

The most recent data on these registers (which is for the period 2014-15) indicates there were 709 patients identified, compared with a figure of 731 for the period 2013-14.

These indicate a prevalence of 0.27 and 0.28 respectively, which is significantly lower than would be expected from the number of deaths in Wolverhampton over the same periods – approximately 2,400 - which suggests that only 30% of people who died were on the register.

More detailed analysis of the register figures for GP Practices across the city indicates very significant variations in the percentage of patients on the register – ranging from a prevalence of 1.63% in one practice in 2014-15 (105 patients) to 0.03% in another (2 patients).

Some GP practices only had 1 patient recorded on their register in either year. In most practices the recorded percentage in 2014-15 had reduced from the figures reported in 2013-14. In some practices the number of patients recorded as being on the register was the same in both years.

This suggests there may be under-recording in GP practices of patients approaching end of life

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY 11 OCTOBER 2016
Agenda item 8

Title of Report:	**Constitution Variation**
Report of:	Corporate Operations Manager
Contact:	Peter McKenzie
Governing Body Action Required:	☒ **Decision** ☐ **Assurance**
Purpose of Report:	To ask the Governing Body to agree to making 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.
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	Developing and Strengthening Leadership Capacity and Capability as a CCG.
Relevance to Board Assurance Framework (BAF):	Outline which Domain(s) the report is relevant to and why
• **Domain 1:** A Well Led Organisation	The Constitution underpins the CCG's Governance Framework and ensuring that it is robust and up to date is fundamental to the CCG's leadership priorities.
• **Domain 3:** Financial Management	The constitution includes the high level framework for the CCG's financial management arrangements (Prime Financial Policies), which are essential for delivering the CCG's financial duties.
• **Domain 5:** Delegated Functions	The proposed amendments incorporate the Terms of Reference for the Joint Committee for exercising delegated functions with NHS England

1. BACKGROUND AND CURRENT SITUATION

1.1. As previously reported, NHS England have been clarifying the process for applying for fully delegated co-commissioning of Primary Care from April 2017. Now more details are available, work has begun to prepare the CCG's application, including the variation of the constitution.

1.2. Other changes to the constitution are required to give effect to the change of membership of the Governing Body in response to statutory guidance on conflict of interests and following reviews of Prime Financial Policies (PFPs) and the Scheme of Reservation and Delegation.

2. PRIMARY CARE CO-COMMISSIONING

2.1. 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. As previously reported, the CCG will be required to establish a Primary Care Committee to exercise the functions delegated to it that complies with the membership requirements in the statutory guidance for managing conflicts of interest.

2.2. The main body of the constitution has been amended to include the appropriate references to the new committee and terms of reference have been drafted based on the current Primary Care Joint Commissioning Committee terms of reference and the model terms of reference supplied by NHS England. The terms of reference will be accompanied by a delegation agreement from NHS England that will set out in more detail the activities and functions that the CCG will be undertaking on their behalf. This agreement will be developed in consultation with NHS England and may result in minor amendments being required to the draft terms of reference prior to the submission of the application by 5 December 2016.

2.3. Work will continue to develop the application for full delegation prior to 5 December 2016 and the Governing Body will receive further details as this work goes on. At this stage, the Governing Body is asked to formally confirm its intention to make an application and to make a recommendation to the CCG membership meeting on 19 October that it be authorised to do so.

3. CONFLICTS OF INTEREST MANAGEMENT – CHANGE TO GOVERNING BODY MEMBERSHIP

3.1. Following the changes to the CCG's arrangements for managing conflicts of interest, in response to new national guidance, the Governing Body has agreed to the appointment of an additional Lay Member for Finance and Performance. The constitution, Standing Orders and Terms of Reference for the Finance and Performance Committee have been updated to reflect this.

3.2. Further minor changes have also been made to the constitution to ensure it remains is consistent with the operational policies. In particular, the categories of relevant interests have been amended to reflect the new national guidance and standing orders have been updated to clarify the arrangements in place when Governing Body meetings cannot be quorate due to clinical conflicts of interest. These changes (along with all of the other changes referenced in this report) are tracked in the updated document.

4. REVIEW OF PRIME FINANCIAL POLICIES AND SCHEME OF RESERVATION AND DELEGATION

4.1. As previously reported, in line with the documented procedure, the CCG's PFPs and Scheme of Reservation and Delegation have been reviewed by the Finance and Performance and Audit and Governance Committees in July 2016. A number of minor, presentational amendments have been made to Sections 1.1.4, 3.4, 3.5, 12.1(c) & 13.4 of the PFPs and the following additions have been made to the Scheme of Reservation and Delegation:-

- Additional item added to include the arrangements for the procurement of external auditors which has recently been delegated to CCGs;
- Additional item added to reflect the Commissioning Committee's role in approving business cases and service developments. This is to replace the item previously included within the Detailed Scheme of Delegation.
- In addition, there has been one presentational amendment to substitute 'the NHS Commissioning Board' for 'NHS England'.

4.2. As with the terms of reference for the Primary Care Commissioning Committee, the Scheme of Reservation and Delegation may require further minor amendment to reflect the delegation agreement with NHS England for full delegation. This will be discussed as the agreement is developed.

5. NEXT STEPS

5.1. As highlighted above, the Governing Body is asked to formally agree to make an application for fully delegated commissioning and to seek the agreement of the CCG Membership to this course of action. In addition, the making of an application to vary the constitution is reserved to the Membership so the Governing Body is also asked to recommend to the Membership that an application is made that includes the above amendments.

5.2. As highlighted above, a number of further amendments may be required to the current drafts of the constitution and appendices attached to this report as a result of preparation for the application for full delegation of Primary Care. The Governing Body is asked to authorise the Chair and Interim Accountable Officer to agree the final versions for submission once the delegation agreement with NHS England is reached.

5.3. NHS England requires the CCG to follow a prescribed process for making an application for a variation, including the completion of an impact assessment that covers issues such as stakeholder engagement and the financial impact of the amendment. This will be signed off by the Accountable Officer and Chair prior to the application being made.

6. CLINICAL VIEW

6.1. Whilst the changes do not have specific clinical implications, this will be discussed at the Membership meeting on 19 October 2016.

7. PATIENT AND PUBLIC VIEW

7.1. Patient and Public input will be detailed as part of the Impact assessment process prior to the application being made. The CCG has previously sought views on the Primary Care strategy which set out the CCG's aspiration to move to full delegation by 2017.

8. RISKS AND IMPLICATIONS

Key Risks

8.1. The risks associated with the application for fully delegated commissioning are being managed through the application process. NHS England require assurance that the CCG will be able to deliver fully delegated commissioning and will be assessed through the proforma provided.

8.2. The other amendments to the Constitution mitigate risks associated with the CCG not having up to date arrangements or, in the case of the changes relating to the management of conflict of interests, arrangements that reflect statutory guidance.

Financial and Resource Implications

8.3. There are no financial implications arising from this report. The resource implications of fully delegated commissioning will be considered through the application process and up to assuming responsibility in April 2017.

Quality and Safety Implications

8.4. There are no Quality and Safety implications arising from this report.

Equality Implications

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

Medicines Management Implications

8.6. There are no Medicines Management implications arising from this report.

Legal and Policy Implications

8.7. The application will be submitted in line with the nationally prescribed process and statutory guidance for constitutional review. This will result in an update to the CCG's published constitution.

9. RECOMMENDATIONS

9.1. That the Governing Body:-

- **Agrees** to make an application for full delegation of Primary Care Commissioning.
- **Recommends** to the Membership that an application for full delegation of Primary Care Commissioning and consequent variation of the Constitution is made, also including the inclusion of the additional Lay Member of the Governing Body, the and amendments to Prime Financial Policies and the Scheme of Reservation and Delegation highlighted in the report.
- **Authorises** the Interim Accountable Officer and the 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.

Name Peter McKenzie
Job Title Corporate Operations Manager
Date: September 2016

RELEVANT BACKGROUND PAPERS

NHS England webpage on delegated commissioning
https://www.england.nhs.uk/commissioning/pc-co-comms/pb-cc-approval/

ATTACHED DOCUMENTS

Amended Constitution
Amended Standing Orders
Amended Scheme of Reservation and Delegation
Amended Terms of Reference – Finance and Performance Committee
Draft Terms of Reference – Primary Care Commissioning Committee

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REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	**Date**
Clinical View	**N/a**	
Public/ Patient View	**N/a**	
Finance Implications discussed with Finance Team	**N/a**	
Quality Implications discussed with Quality and Risk Team	**N/a**	
Medicines Management Implications discussed with Medicines Management team	**N/a**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/a**	
Information Governance implications discussed with IG Support Officer	**N/a**	
Legal/ Policy implications discussed with Corporate Operations Manager	Report Author	**29/09/2016**
Signed off by Report Owner (Must be completed)	**Peter McKenzie**	**29/09/2016**

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NHS WOLVERHAMPTON
CLINICAL COMMISSIONING GROUP

CONSTITUTION APPENDIX E

STANDING ORDERS

Version: [6]

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1. STATUTORY FRAMEWORK AND STATUS

1.1. Introduction

1.1.1. These Standing Orders have been drawn up to regulate the proceedings of the NHS Wolverhampton Clinical Commissioning Group so that it can fulfil its obligations, as set out largely in the 2006 Act, as amended by the 2012 Act and related regulations. They are effective from the date the group is established and are deemed to be part of its constitution, as noted at paragraph 10.2 thereof.

1.1.2. The Standing Orders, together with the group's Scheme of Reservation and Delegation and the group's Prime Financial Policies, provide a procedural framework within which the group discharges its business. They set out:

a) the arrangements for conducting the business of the group;

b) the appointment of member practice representatives;

c) the procedure to be followed at meetings of the group, the governing body and any committees or sub-committees of the group or the governing body;

d) the process to delegate powers,

e) the protocol for declaration of interests and standards of conduct.

These arrangements must comply, and be consistent where applicable, with requirements set out in the 2006 Act (as amended by the 2012 Act) and related regulations and take account as appropriate of any relevant guidance.

1.1.3. Group members, employees, members of the governing body, members of the governing body's committees and sub-committees, members of the group's committees and sub-committees and persons working on behalf of the group should be aware that these three documents are part of the group's constitution and, where necessary, be familiar with their detailed provisions. Failure to comply with them may be regarded as a disciplinary matter that could result in dismissal.

1.2. Schedule of matters reserved to the clinical commissioning group and the Scheme of Reservation and Delegation

1.2.1. The 2006 Act (as amended by the 2012 Act) provides the group with powers to delegate the group's functions and those of the governing body to certain bodies (such as committees) and certain persons. The group has decided that certain decisions may only be exercised by the group in formal session. These decisions and also those delegated are contained in the group's Scheme of Reservation and Delegation.

2. THE CLINICAL COMMISSIONING GROUP: COMPOSITION OF MEMBERSHIP, KEY ROLES AND APPOINTMENT PROCESSES

2.1. Composition of membership

2.1.1. Part 3 and Appendix B of the group's constitution provide details of the membership of the group.

2.1.2. Part 6 of the group's constitution provides details of the governing structure used in the group's decision-making processes, whilst Part 7 of the constitution outlines certain key roles and responsibilities within the group and its governing body, including the role of practice representatives at paragraph 7.1.

2.2. Key Roles and Appointment Processes

2.2.1. Paragraph 6.9.2 of the group's constitution sets out the composition of the group's governing body whilst Part 7 of the group's constitution identifies certain key roles and responsibilities within the group and its governing body. These Standing Orders set out how the group appoints individuals to these key positions using best practice and with reference to the national guidance on roles, attributes and skills.

2.2.2. The chair of the governing body, see 6.9.2(a) and 7.4 of the constitution, is subject to the following:

a) **Nominations** – before the first meeting of the governing body and as determined by (d) below thereafter, an eligible individual may put themselves forward for election to this position by notifying the Accountable Officer and each of the other elected members at least 48 hours before the relevant meeting;

b) **Eligibility** – any of the elected members unless disqualified by virtue of (e) below;

c) **Appointment process** – election, by elected members only, in a secret ballot of the governing body on the basis of one vote per person with voters who know they will be absent allowed to submit their vote to the meeting in writing;

d) **Term of office** – three years

e) **Eligibility for reappointment** – no individual will serve more than two consecutive terms of office;

f) **Grounds for removal from office** – no longer being a member of the governing body or a failure to perform to the required standard;

g) **Notice period** – three months to be served in writing to the Accountable Officer.

2.2.3. The deputy chair of the governing body, see 7.5 of the constitution, will be the lay member selected for their knowledge of Wolverhampton (constitution 6.9.2 (c) (ii)). The governing body's chair is to be an elected member and if, in addition the chair is a health professional, and Regulations (SI 2012/1631) require that the deputy chair's position to be held by a lay member.

2.2.4. The existing GP members of the governing body seeking re-election and prospective members seeking membership, (see 6.9.2(b) of the constitution), will be subject to the following criteria and process :

a) **Nominations** – any eligible GP can put themselves forward for election to the governing body and this must be done in the format, to the named individual(s) and by the date/time specified in the rules for that election;

b) **Eligibility** – any GP working in any member practice(s) (other than on a locum basis) on the date specified by the rules for the election, unless disqualified by virtue of regulations or (e) below, subject to paragraph 8.3.6 of the constitution;

c) **Appointment process** – election by secret ballot, overseen by the Local Medical Committee, of all eligible GPs, as defined at (b) above, with each GP's vote allocated a weight based on the list size of their practice(s) (0.1 per complete 100 patients) and then allocated pro rata according to the number of sessions per week that they work, both as recorded by the group on dates specified by the rules for the election;

d) **Term of office** – three years subject to 2.2.2 (f) (notice period) below ;

e) **Eligibility for reappointment** – no individual will serve more than two consecutive terms of office;

f) **Grounds for removal from office** – no longer being eligible as defined at (b) above, failure to perform to the required standard or any proven misconduct that would in the case of an employee of the group, result in their dismissal;

g) **Notice period** – three months to be served in writing to the Chair;

h) **By-elections** – if any of the eight places fall vacant, there will be a by-election to fill the vacancy for the remainder of that term. If the number of places does not fall below seven but a vacancy arises, the governing body will decide whether there shall be an election to fill that vacancy. The winner of that election will be deemed to have served one term of office which shall be discounted for the purposes of (e) above only if their time in office is over eighteen months.

2.2.5. The practice representatives, see 7.1 of the constitution, are subject to the following:

a) **Nominations** – any eligible GP or other primary care health professional can put themselves forward for selection as the practice representative;

b) **Eligibility** – any GP or other primary care health professional working in the member practice other than on a locum basis only;

c) **Appointment process** – selection by the practice using a voting procedure including all of its eligible GPs and primary care health professionals and which has been documented and lodged with the group's Accountable Officer, who will then be notified in writing as to who each representative is;

d) **Term of office** – three years subject to f) (removal from office) and g) (notice period);

e) **Eligibility for reappointment** – no individual will serve more than three consecutive terms of office;

f) **Grounds for removal from office** – no longer being eligible as defined at (b) above or failure to perform to the required standard;

g) **Notice period** – one month to be served in writing to the Accountable Officer.

2.2.6. The lay members, see 6.9.2 (c) and (d) of the constitution, are subject to the following:

a) **Nominations** – persons who meet the requirements of and are not disqualified by regulations, will be invited to apply for these positions;

b) **Eligibility** – further qualifying criteria for each of the positions will be clearly set out and only applicants who meet those criteria will be considered, subject to paragraph 8.3.6 of the constitution;

c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to each position;

d) **Term of office** – five years, with the first term starting on the effective date of the group's constitution;

e) **Eligibility for reappointment** – no individual will serve more than two terms of office

f) **Grounds for removal from office** – no longer being eligible as defined at (b) above, failure to perform to the required standard or any proven misconduct that would in the case of an employee of the group result in their dismissal;

g) **Notice period** – one month to be served in writing to the chair.

2.2.7. The registered nurse, see 6.6.2 (e) of the constitution, is subject to the following:

a) **Nominations** – membership of the governing body will rest with the individual appointed as the group's Executive Nurse and applications will be sought by advertising that position;

b) **Eligibility –** a registered nurse who will not, once appointed, also be employed in general practice or by any organisation from which the group secures any significant volume of provision, is not otherwise disqualified by regulations and who meets the specific criteria identified for the position, subject to paragraph 8.3.6 of the constitution;

c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to the position;

d) Terms relating to tenure in post, including cessation provisions will be determined by the post-holder's contract of employment with the group.

2.2.8. The secondary care specialist doctor, see 6.9.2 (f) of the constitution, is subject to the following:

a) **Nominations** – applications will be sought by advertising the position;

b) **Eligibility** – a doctor who is/has been a secondary care specialist with a high level of understanding of how care is delivered in a secondary care setting, who is not employed in a member practice or any organisation from which the group secures any significant volume of provision, is not otherwise disqualified by regulations and who meets the specific criteria identified for the position, subject to paragraph 8.3.6 of the constitution;

c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to the position;

d) **Term of office** – five years, with the first term starting on the effective date of the group's constitution;

e) **Eligibility for reappointment** – no individual will serve more than two terms of office;

f) **Grounds for removal from office** – no longer being eligible as defined at (b) above, failure to perform to the required standard or any proven misconduct that would in the case of an employee of the group result in their dismissal;

g) **Notice period** – one month to be served in writing to the Chair.

2.2.9. The Accountable Officer, see 6.9.2(g) and 7.6 of the constitution is subject to the following:

a) **Nominations** – membership of the governing body will rest with the individual appointed as the group's Chief Officer and applications will be sought by advertising that position;

b) **Eligibility** – the qualifying criteria for the position will be clearly set out and only applicants who meet those criteria and are not disqualified by regulations will be considered, subject to paragraph 8.3.6 of the constitution;

c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to the position. The appointment will then be formally confirmed by the NHS Commissioning Board;

d) Terms relating to tenure in post, including cessation provisions will be determined by the post-holder's contract of employment with the group.

2.2.10. The Chief Finance Officer, see 6.9.2(h) and 7.7 of the constitution is subject to the following:

a) **Nominations** – applications for post as employee of the group;

b) **Eligibility** – holder of recognised accountancy qualification with current membership of the relevant professional body who meets the other specified criteria identified for the position and is not disqualified by regulations, subject to paragraph 8.3.6 of the constitution;

c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to the position;

d) Terms relating to tenure in post, including cessation provisions will be determined by the post-holder's contract of employment with the group.
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2.2.11. The Group's Director of Strategy and Transformation, see 6.9.2(h) is subject to the following;

a) **Nominations** – applications for post as employee of the group;

b) **Eligibility** – the qualifying criteria for the position will be clearly set out and only applicants who meet those criteria and are not disqualified by regulations will be considered, subject to paragraph 8.3.6 of the constitution;

c) **Appointment process –** eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to the position;

d) Terms relating to tenure in post, including cessation provisions will be determined by the post-holder's contract of employment with the group.

2.2.12. The practice manager representative, see 6.9.2(j) of the constitution is subject to the following:

a) **Nominations** – applications will be sought by advertising the position;

b) **Eligibility** – anyone who is/has been a GP practice manager with a high level of understanding of that role, who meets the other specified criteria identified for the position and is not disqualified by regulations, subject to paragraph 8.3.6 of the constitution;

c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to the position;

d) **Term of office** – five years, with the first term starting on the effective date of the group's constitution;

e) **Eligibility for reappointment** – no individual will serve more than two consecutive terms of office ;

f) **Grounds for removal from office** – no longer being eligible as defined at (b) above, failure to perform to the required standard or any proven misconduct that would in the case of an employee of the group result in their dismissal;

g) **Notice period** – one month's to be served in writing to the chair.

3. MEETINGS OF THE CLINICAL COMMISSIONING GROUP

3.1. Calling meetings

3.1.1. Ordinary meetings of the group will be held quarterly with at least one month's notice given to all members via an e-mail to their practice representative. The details of the date, time and venue of these meetings will be publicised on the group's website www.wolverhamptonccg.nhs.uk.

3.1.2. An extraordinary meeting of the group will be held if deemed necessary by the governing body or if requested in writing to the chair of the governing body by at least ten practice representatives. At least one week's notice will be given to all members via an e-mail to their practice representative. Unless otherwise determined by the governing body or the chair thereof, because of the nature of the business of the meeting, the details of the date, time and venue of such

meetings will be publicised on the group's website www.wolverhamptonccg.nhs.uk.

3.1.3. The governing body will schedule its meetings in advance and hold at least six such meetings in each financial year. Details of meeting dates, times and venues will be published on the group's website www.wolverhamptonccg.nhs.uk and no meeting will be rescheduled without at least one week's notice of the re-arranged date.

3.1.4. Committees of the group or the governing body and any sub-committees thereof will hold meetings as specified in their terms of reference.

3.2. Agenda, supporting papers and business to be transacted

3.2.1. Items of business to be transacted for inclusion on the agenda of a meeting of the group or the governing body need to be notified to the chair of the governing body at least ten working days (excluding weekends and bank holidays) before the meeting takes place. Supporting papers for such items need to be submitted such that the agenda and supporting papers will be circulated to all members of a meeting at least five working days before the date the meeting will take place. Addition of further agenda items or acceptance by the meeting of supporting papers after these deadlines will be at the discretion of the chair of the governing body or other person chairing the meeting as appropriate.

3.2.2. Agendas and certain papers for meetings of the group and its governing body will be published on the group's website www.wolverhamptonccg.nhs.uk.

3.3. Petitions

3.3.1. Where a petition has been received by the group, the chair of the governing body shall include the petition as an item for the agenda of the next meeting of the governing body.

3.4. Chair of a meeting

3.4.1. At any meeting of the group or its governing body, the chair of the governing body will preside. At any meeting of a committee or sub-committee, its chair as defined in its terms of reference will preside. If the designated chair is absent from any meeting, the designated deputy chair, if any and if present, shall preside. Otherwise a member of the forum will be chosen by the members present, or by a majority of them, and shall preside.

3.4.2. If the chair is absent temporarily on the grounds of a declared conflict of interest the deputy chair, if present, will preside for the relevant business of the meeting. If both the chair and deputy chair are absent or disqualified from participating, a member of the forum who is able to participate will be chosen by the members present, or by a majority of them, and will preside.

3.5. Chair's ruling

3.5.1. The decision of the chair of the meeting on questions of order, relevancy and regularity and their interpretation of the constitution, Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies at the meeting, shall be final.

3.6. Quorum

3.6.1. Meetings of the group will be quorate if more than 50% of the practices in the group are represented by their practice representative or any substitute notified in writing to the Accountable Officer at least 24 hours before the meeting was scheduled to start. If enough members are disqualified from taking part in a vote due to a declared interest that the meeting ceases to be quorate for that item of business, no such vote will be taken and the item and/or the remainder of the meeting (if it cannot be quorate thereafter) shall be adjourned and the business remaining on the agenda dealt with on a date to be agreed.

3.6.2. Meetings of the governing body will be quorate if more than 50% of the members as defined by paragraph 6.9.2 of the constitution, including at least half of the elected members, are present or represented by an individual as notified to the chair more than 24 hours before the meeting was scheduled to start. If the reason for the meeting not being quorate is that all or some of the elected members and the practice manager are disqualified from taking part in a vote due to a declared interest, in line with the group's arrangements for managing conflicts of interest, the meeting will be quorate provided that more than 50% of the other members of the Governing Body are present. . The chair of the meeting for that item of business will ensure that the requirements of the constitution at 8.4.9 and 8.4.10 have been met.

3.6.3. For all other of the group's committees and sub-committees, including the governing body's committees and sub-committees, the details of the quorum for these meetings and status of representatives are set out in the appropriate terms of reference and are governed by the constitution at 8.4.8 to 8.4.10 if declared interests reduce the membership for any item of business.

3.7. **Decision making**

3.7.1. Chapter 6 of the group's constitution, together with the Scheme of Reservation and Delegation, sets out the governing structure for the exercise of the group's statutory functions. Generally, it is expected that at meetings of the group and the governing body, decisions will be reached by consensus. Should this not be possible then a vote of members will be required, the processes for which are set out below.

3.7.2. In the event of a vote being necessary at a meeting of the group:

a) **Eligibility** – practice representatives, or any substitute notified in writing to the Accountable Officer at least 24 hours before the meeting was scheduled to start, will be able to cast one vote on behalf of their practice.

b) **Majority necessary to confirm a decision** - a simple majority of the members present and voting at the meeting;

c) **Casting vote** - the chair of the meeting will have a casting vote in the unlikely event of no overall majority being established.

3.7.3. In the event of a vote (other than those described at 2.2 above) being necessary at a meeting of the governing body:

a) **Eligibility** – members of the governing body as defined by paragraph 6.9.2 of the constitution will be able to cast one vote but others in attendance at the meeting will not. Any member who cannot attend the meeting and wishes their vote to be cast by a representative must have notified the Chair of the identity of that individual more than 24 hours before the meeting was scheduled to start;

b) **Majority necessary to confirm a decision** – a simple majority

c) **Casting vote** - the chair of the meeting will have a casting vote in the event of no overall majority being established.

3.7.4. If a vote is taken the outcome of the vote and any dissenting views must be recorded in the minutes of the meeting.

3.7.5. For all other of the group's committees and sub-committees, including the governing body's committees and sub-committees, any vote will be decided at a quorate meeting by a simple majority, as set out in the respective terms of reference, with the chair of the meeting having a casting vote if necessary.

3.8. Emergency powers and urgent decisions

3.8.1. Those powers that the group has reserved to itself (see SO 1.2) may, in an emergency or unforeseen circumstances, be exercised by the Chair of the governing body and the Accountable Officer after consultation with at least two practice representatives and the Chief Finance Officer if the group will, or is likely to, incur any excessive or unnecessary expenditure as a result of them not utilising the emergency powers, suffer exposure to a risk outside the group's stated risk appetite (including but not limited to prospective reputational damage) or other matter which, in the opinion of the Chair, requires an urgent decision to be taken prior to the next meeting of the group. The exercise of such powers will be reported to all practice representatives and subsequently ratified (or not as the case may be) and recorded at the next meeting of the group.

3.8.2. Those powers that the group has delegated to the governing body may in an emergency or the need for an urgent decision be exercised by the Chair of the governing body and the Accountable Officer after consultation with at least two other elected members of the governing body and the Chief Finance Officer if the group will, or is likely to, incur any excessive or unnecessary expenditure as a result of them not utilising the emergency powers, suffer exposure to a risk

outside the group's stated risk appetite (including but not limited to prospective reputational damage) or other matter which, in the opinion of the Chair, requires an urgent decision to be taken prior to the next meeting of the governing body The exercise of such powers will be reported to all members of the governing body as defined by paragraph 6.9.2 of the constitution and subsequently ratified (or not as the case may be) and recorded at the next meeting of the governing body. An urgent decision is one that needs to be taken before the next meeting of the governing body in order to ensure that the group meets it statutory, regulatory, governance and contractual obligations.

3.8.3. The provisions of paragraphs 3.8.1 and 3.8.2 shall apply (suitably modified) to the any committees established by the group and the governing body.

3.9. Suspension of Standing Orders

3.9.1. Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or NHS England, any part of these Standing Orders may be suspended at any meeting, provided a simple majority plus one of the voting members of that meeting are in agreement.

3.9.2. A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

3.9.3. A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the governing body's Audit and Governance Committee for review of the reasonableness of the decision to suspend Standing Orders.

3.10. Records of Attendance

3.10.1. The names of all voting members (or their representatives) present at any meeting of the group, its governing body and any committee/sub-committee must be recorded in the minutes of that meeting together with the names of any attendees at such meetings.

3.11. Minutes

3.11.1. It will be the responsibility of the person chairing any meeting to ensure that an individual has been identified to take and draft the minutes of that meeting. The-chair of that meeting will confirm the accuracy of those minutes before they are presented to the next meeting of that forum for formal approval and be signed off by the person chairing that subsequent meeting.

3.11.2. Minutes of meetings of the group and its governing body will be among the papers published on the group's website www.wolverhamptonccg.nhs.uk.

3.12. Those invited to attend and admission of public and the press

3.12.1. Employees of and providers of relevant services to the group and other representatives of any organisations with which it jointly commissions or from

whom it commissions healthcare services will be invited to attend meetings of the governing body whenever the transaction of its business will be made more efficient and effective by their presence.

3.12.2. In addition, representatives of the following will be invited to attend and contribute from their perspective, to all meetings of the governing body as observers, declaring any interests as appropriate:

- the Local Medical Committee, as statutory representatives of the GP profession;
- Wolverhampton City Council, as key commissioning partners and host of the local Public Health function;
- Wolverhampton Health and Wellbeing Board, through which the group and the Council will develop joint strategic needs assessments and joint strategies;
- local HealthWatch to represent patients/carers.

3.12.3. The public and representatives of the press may attend all meetings of the group and its governing body unless it is necessary to ask them and those invited to attend as observers, to withdraw under: (a) Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960 because of the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest; (b) Section 1(8) of that Act in the interests of public order.

3.12.4. Members and employees of the group who remain at a meeting whilst confidential business is discussed will treat the relevant papers, discussion and minutes as absolutely confidential d and not to be disclosed outside of the group without express written permission to do so from the Chair or Deputy Chair of the governing body, the Accountable Officer or the Chair of the Audit and Governance Committee.

3.12.5. No member of the public or representative of the press will record or transmit a meeting of the group or its governing body without express permission from the chair of the meeting.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1. Appointment of committees and sub-committees

4.1.1. The group may appoint committees and sub-committees of the group, subject to any regulations made by the Secretary of State, and make provision for the appointment of committees and sub-committees of its governing body. Where such committees and sub-committees of the group or the governing body are appointed they are included in Chapter 6 of the group's constitution.

4.1.2. Other than where there are statutory requirements, such as in relation to the governing body's Audit and Governance and Remuneration committees, the group shall determine the membership and terms of reference of committees and sub-committees and shall, if it requires, receive and consider reports of such committees at the next appropriate meeting of the group.

4.1.3. The provisions of these Standing Orders shall apply where relevant to the operation of the governing body, the governing body's committees and sub-committees and all committees and sub-committees unless stated otherwise in the committee's or sub-committee's terms of reference.

4.2. Terms of Reference

4.2.1. Terms of reference shall have effect as if incorporated into the constitution and shall be appended to it.

4.3. Delegation of Powers by Committees to Sub-committees

4.3.1. Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the group.

4.4. Approval of Appointments to Committees and Sub-Committees

4.4.1. The group shall approve the appointments to each of the committees and sub-committees which it has formally constituted including those of the governing body. The Remuneration Committee will agree such travelling or other allowances for the members of such forums, as it considers appropriate.

5. DUTY TO REPORT NON-COMPLIANCE WITH STANDING ORDERS

5.1. If for any reason these Standing Orders are not complied with, full details of the non-compliance, any justification for non-compliance and the circumstances around the non-compliance will be reported to the next formal meeting of the governing body for action or ratification. All members of the group and staff have a duty to disclose any non-compliance with these Standing Orders to the Accountable Officer as soon as possible.

6. USE OF SEAL AND AUTHORISATION OF DOCUMENTS

6.1. Clinical Commissioning Group's seal

6.1.1. The group may have a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature:

a) the Accountable Officer;

b) the Chair of the governing body;

c) the Chief Finance Officer;

6.1.2 A register of sealings will be maintained by the Corporate Operations Manager

6.2. Execution of a document by signature

6.2.1. The following individuals are authorised to execute a document on behalf of the group by their signature.

a) the Accountable Officer

b) the Chair of the governing body

c) the Chief Finance Officer

7. OVERLAP WITH OTHER CLINICAL COMMISSIONING GROUP POLICY STATEMENTS AND PROCEDURES

7.1. Policy statements: general principles

7.1.1. The group will from time to time agree and approve policy statements and procedures which will apply to all or specific groups of staff employed by NHS Wolverhampton Clinical Commissioning Group. The decisions to approve such policies and procedures will be recorded in an appropriate group or governing body minute, will be deemed where appropriate to be an integral part of the group's standing orders and will indicate as appropriate, those for which non-compliance may be regarded as a disciplinary matter that could result in dismissal.

NHS Wolverhampton
Clinical Commissioning Group
Constitution Appendix H4

Governing Body's
Finance and Performance Committee
Terms of Reference

1. Introduction

The Finance and Performance Committee (FPC) is established in accordance with paragraph 6.9.3(d) of NHS Wolverhampton City Clinical Commissioning Group's constitution, Standing Orders and Scheme of Reservation and Delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the FPC and shall have effect as if incorporated into the constitution and standing orders.

The FPC will evaluate its own performance and terms of reference annually. Any resulting changes to the terms of reference and/or concerns in relation to the performance evaluation will be received and considered for approval by the governing body, or the group if they relate to the membership of the committee (Standing Order 4.4), before becoming part of an application for variation to be approved by the group and submitted to NHS England (constitution 1.4). The terms of reference will be published on the group's website (www.wolverhamptonccg.nhs.uk) and available by post or email, if requested.

2. Membership

The Chair of the FPC will be the lay member of the governing body for finance and performance.

The number of members of FPC shall be at least 5.

In the event of the Chair of the FPC being unable to attend all or part of a meeting, the members of FPC will nominate a replacement from within the membership to deputise for that meeting.

The other members of the FPC will be appointed by the group to include other members of the governing body including the Chief Finance Officer and employees of the group including at least one representative of the Commissioning function save that, subject to the qualifying proviso below, members of FPC need not be members of the governing body

No individual who could not be a member of the group's governing body by virtue of sections (4) to (10) of Schedule 5 of the 2012 Regulations (SI 2012/1631) will be eligible to be a non-governing body member of the group's FPC

3. In attendance

Employees of and providers of relevant services to the group and representatives of any organisations with which it jointly commissions or from whom it commissions healthcare services may be invited to attend when the FPC is discussing areas that are the responsibility of that person.

4. Secretary

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

5. Quorum

A meeting of the FPC will be quorate provided that three members are present of whom at least one is a member of the governing body (the Chief Finance Officer not being counted as a member of the governing body for this purpose), the Chief Finance Officer or his/her authorised deputy and one other FPC member.

6. Voting

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

7. Frequency and notice of meetings

The FPC will meet at least eight times per annum with meeting dates scheduled in advance for at least 12 months, save in an emergency when the Chair of FPC may call a meeting of his/her volition or at the request of a member(s) with the Chair's consent.. No unscheduled or rescheduled meetings will take place without members usually having at least ten days of the date and in an emergency, standing order 3.8 (Emergency Powers and Urgent Decisions) shall apply. The agenda and supporting papers will be circulated to all members at least five working days before the date the meeting will take place unless a shorter time period for circulation of papers is necessary due to a meeting being re-scheduled at short notice..

8. Remit and responsibilities of the committee

The FPC is accountable to the governing body and its remit is to provide the governing body with assurance on issues related to the finances, including financial health, of the group and the achievement of performance objectives and targets. It will deliver this remit in the context of the group's priorities, as they emerge and develop, and the risks associated with achieving them.

The specific duties delegated to or conferred on the FPC by the group of its governing body are:

- to support the Chief Finance Officer in the delivery of the general financial duties (constitution 5.3.1 – 5.3.3);
- to report to the governing body on areas of concern regarding financial and performance issues;
- to receive reports from the group's representative on the Wolverhampton Health and Wellbeing Board with regard to development of the joint assessments and strategies and delivery of the latter (constitution 5.1.2(c)(ii));
- to monitor the group's delivery of the duty to act effectively, efficiently and economically (constitution 5.2.3);
- to monitor the group's delivery of the duty to have regard to the need to reduce inequalities (constitution 5.2.6);
- review the Chief Finance Officer's proposals for any changes to the Prime Financial Policies prior to scrutiny of them by the Audit and Governance Committee (PFP 1.5.1)
- approval of detailed financial policies (PFP 1.1.3);
- to consider reports from the Chief Finance Officer regarding significant variances from budgeted performance (PFP 7.3) and approve any changes to budgets not significant enough to require approval by the governing body (PFP 7.4);

- to consider reports from management regarding significant variances from non-financial performance targets;
- agree the Chief Finance Officer's timetable for producing the annual accounts and report (PFP 8.1(a));
- approve the group's overall banking arrangements (PFP 11.2);
- receive reports detailing actual and forecast expenditure and activity for all healthcare contracts (PFP14.3).

It will deliver these duties by developing and delivering annual work programmes giving appropriate focus to the following:
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- receive and consider detailed monthly monitoring reports and year-end forecast of performance against financial and performance targets;
- review plans for and delivery of initiatives under QIPP and any subsequent programme of that nature;
- to make recommendations as necessary to the governing body on the remedial actions to be taken with regard to finance and performance issues and risks, including in-year changes to budgets; and
- to report annually to the governing body in relation to how FPC has discharged its duties.

9. Relationship with the governing body

For the next meeting of the governing body following each meeting of the FPC, the Chair of the committee will provide a written summary of the key matters covered by the meeting.

The minutes of each meeting of the FPC, as agreed at the subsequent meeting, will be presented to the next meeting of the governing body for information.

The Chair of the FPC will report by exception to the next meeting of the governing body any significant financial or performance issues brought to the Chair's attention other than at a meeting of the Committee.

10. Policy and best practice

In seeking to apply best practice in the decision- making process, the QSC has full authority to commission any reports, surveys or other information that it deems necessary to assist it in fulfilling its obligations.

NHS Wolverhampton
Clinical Commissioning Group
Constitution Appendix H6

The Primary Care Commissioning Committee Terms of Reference

1. Introduction

1.1 Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting Clinical Commissioning Groups (CCGs) to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England and CCGs would delegate the exercise of certain specified primary care commissioning functions to a CCG.

1.2 In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to Wolverhampton CCG. The delegation is set out in Schedule 1.

1.3 The CCG has established the Wolverhampton CCG Primary Care Commissioning Committee ("the Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of these delegated powers for commissioning primary medical services for the people of Wolverhampton.

2. Statutory Framework

2.1 NHS England has delegated authority to the CCG to exercise the commissioning functions set out in Schedule 2 in accordance with Section 13Z of The National Health Service Act 2006 (as amended) ("NHS Act").

2.2 Section 13Z of the NHS Act further provides that arrangements made under that section may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

2.3 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

a) Management of conflicts of interest (section 14O);
b) Duty to promote the NHS Constitution (section 14P);
c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);
d) Duty as to improvement in quality of services (section 14R);
e) Duty in relation to quality of primary medical services (section 14S);
f) Duties as to reducing inequalities (section 14T);
g) Duty to promote the involvement of each patient (section 14U);
h) Duty as to patient choice (section 14V);
i) Duty as to promoting integration (section 14Z1);
j) Public involvement and consultation (section 14Z2).

2.4 The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those functions set out below:-

- Duty to have regard to impact on services in certain areas (section 13O);
- Duty as respects variation in provision of health services (section 13P).

2.5 The Committee is established as a committee of the Governing Body of the CCG in accordance with Schedule 1A of the NHS Act.

2.6 The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

3. Role of the Committee

3.1 The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in Wolverhampton, under delegated authority from NHS England.

3.2 The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

3.3 The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act

except those relating to individual GP performance management, which have been reserved to NHS England. This includes the following activities:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

3.4 The Committee will also be responsible for maintaining an overview of the CCG's other activities in relation to the delegated functions related to Primary Care and ensuring that they are aligned with the CCG's Primary Care strategy. These activities include:-

- Planning for sustainable primary medical care services in Wolverhampton;
- Reviewing primary medical care services in Dudley with the aim of further improving the care provided to patients
- Co-ordinating the approach to the commissioning of primary care services generally;
- Managing the budget for commissioning of primary medical care services in Wolverhampton.

3.3 In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Wolverhampton CCG, which will sit alongside the delegation and terms of reference.

4. Geographical coverage

4.1 The Committee will comprise the Wolverhampton CCG (The CCG). It will undertake the function of jointly commissioning primary medical services for Wolverhampton.

5. Membership

5.1 The Membership of the Committee shall consist of:-

- The Deputy Chair of the CCG's Governing Body

- The CCG Governing Body Lay Member for Finance and Performance
- Two Executive Members of the CCG's Governing Body (currently the Director of Strategy and Transformation and the Executive Director of Nursing and Quality)
- The Three GPs elected to the CCG Governing Body as Locality Leads (Non-Voting)
- Two Patient Representatives

5.2 The Chair of the Joint Committee shall be the Deputy Chair of the CCG's Governing Body

5.3 The Vice Chair of the Joint Committee shall be the CCG Governing Body Lay Member for Finance and Performance.

5.4 Any member of the committee may nominate a substitute to attend a meeting on their behalf, provided that they notify the Chair 24 hours before the meeting.

6. Invited Attendees

6.1 Both a representative of Healthwatch Wolverhampton and a representative of the Wolverhampton Health and Wellbeing Board (who must represent Wolverhampton City Council on the Board) shall be invited to attend meetings of the Committee as a non-voting observer.

6.2 The observers shall be invited to provide assurance that the provisions for managing conflicts of interest are being correctly applied and shall be entitled to attend private sessions of the Joint Committee.

6.3 The Joint Committee may also call additional experts to attend meetings on an ad hoc basis to inform discussions.

7. Meetings and Voting

7.1 The Committee will operate in line with the CCG's Standing Orders and Policy for Declaring and Managing Interests. The agenda and supporting papers will be circulated to all members at least five working days before the date the meeting will take place unless a shorter time period for circulation of papers is necessary due to a meeting being re-scheduled at short notice.

7.3 Decisions of the Committee should be reached by consensus where possible. Where this is not possible, a vote will be taken with a simple majority of the votes cast being required to reach a decision with the Chair having a second and casting vote in the event of a tie.
N.B. In line with national statutory guidance, the GP representatives on the Committee shall not be entitled to vote.

7.3 Meetings of the Joint Committee shall be held in public, unless the Committee resolves to exclude the public from either the whole or part of the proceedings whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

7.4 Members of the Joint Committee have a collective responsibility for the operation of the Joint Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

7.5 Members of the Joint Committee shall respect confidentiality requirements as set out in the Standing Orders referred to above unless separate confidentiality requirements are set out for the joint committee in which event these shall be observed.

8. Quorum

8.1 Meetings of the Committee shall be quorate when over 50% of its members, including the Chair or Vice Chair and at least one Executive Governing Body member is present and overall make up of those present is such that there is a majority of non-clinical members.

9. Frequency of Meetings

9.1 The Committee shall agree a regular programme of meetings each year. In addition, the Chair may call additional meetings if they are required in line with the provisions for notice of meetings set out above.

10. Secretary

10.1 A named individual (or his/her nominee) shall be responsible for supporting the Chair in the management of the Joint Committee's business and for

drawing members' attention to best practice, national guidance and other relevant documents as appropriate.

10.2 The Secretary will circulate the minutes and action notes of the committee with 3 working days of the meeting to all members and present the minutes and action notes to NHS West Midlands and the governing body of the CCG.

10.3 The Secretary will also provide an executive summary report which will presented to NHS West Midlands and the governing body of the CCG each month for information.

11. Accountability of the Committee

11.1 The Committee will be directly accountable for the commitment of the resources / budget delegated to the CCG by NHS England for the purpose of commissioning primary care medical services. This includes accountability for determining appropriate arrangements for the assessment and procurement of primary care medical services, and ensuring that the CCG's responsibilities for consulting with its GP members and the public are properly accounted for as part of the established commissioning arrangements.

11.2 For the avoidance of doubt, the CCG's Scheme of Reservation & Delegation, Standing Orders and Prime Financial Policies will prevail in the event of any conflict between these terms of reference and the aforementioned documents.

11.3 The Committee is accountable to the governing body to ensure that it is effectively discharging its functions.

12. Procurement of Agreed Services

12.1 The procurement arrangements will be set out in the delegation agreement (Schedule 1 and 2 to this Terms of Reference between NHS Wolverhampton CCG and NHS England.

13. Decisions

13.1 The Committee will make decisions within the bounds of its remit set out in paragraph 3 above. The decisions of the Joint Committee shall be binding on NHS England and NHS Wolverhampton CCG and will be published by both parties.

14. Review of Terms of Reference

14.1 These terms of reference will be formally reviewed by the Committee in April of each year, following the year in which the committee is created and any recommendations for changes will be made to the Governing Body.

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NHS WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

CONSTITUTION APPENDIX G

PRIME FINANCIAL POLICIES

Version: [6]

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1. INTRODUCTION

1.1. General

1.1.1. These Prime Financial Policies shall have effect as if incorporated into the group's constitution as noted at paragraph 10.2 thereof.

1.1.2. The Prime Financial Policies are part of the group's control environment for managing the organisation's financial affairs. They contribute to good corporate governance, internal control and management of risks. They enable sound administration; lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services. They also help the Accountable Officer and Chief Finance Officer to effectively perform their duties and responsibilities and identify the financial responsibilities applying to everyone working for the group and its constituent organisations. They are used in conjunction with the Standing Orders and Scheme of Reservation and Delegation.

1.1.3. In support of these Prime Financial Policies, the group has prepared detailed financial policies that provide day-to-day procedural guidance. These are not part of the constitution and any changes to them will be approved by the Finance and Performance Committee. A list of the group's detailed financial policies is published and maintained on the group's website at www.wolverhamptonccg.nhs.uk. The group refers to these prime and detailed financial policies together as the group's financial policies.

1.1.4. These prime financial policies identify the financial responsibilities which apply to everyone working for the group and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed financial policies. The Finance and Performance Committee is responsible for approving all detailed financial policies. Should any difficulties arise regarding the interpretation or application of any of these policies then the advice of the Chief Finance Officer must be sought before acting. The user of these prime financial policies should also be familiar with and comply with the provisions of the group's constitution, standing orders and scheme of reservation and delegation. Failure to comply with them may be regarded as a disciplinary matter that could result in dismissal.

1.2. Overriding Prime Financial Policies

1.2.1. If for any reason these prime financial policies are not complied with, full details of the non-compliance, any justification for and the circumstances around it will be reported to the next formal meeting of the Audit and Governance Committee for referring action or ratification. All of the group's members and employees have a duty to disclose any such non-compliance to the Chief Finance Officer as soon as possible.

1.3. Responsibilities and delegation

1.3.1. The roles and responsibilities of the group's members, employees, members of the governing body, members of the governing body's committees or sub-committees, members of the group's committees and sub-committees (if any) and persons working on behalf of the group are set out in chapters 6 and 7 of the constitution.

1.3.2. The financial decisions delegated by members of the group are set out in the group's Scheme of Reservation and Delegation or the detailed scheme of delegation as appropriate.

1.4. Contractors and their employees

1.4.1. Any contractor or employee of a contractor who is empowered by the group to commit the group to expenditure or who is authorised to obtain income will be covered by these instructions. It is the responsibility of the Chief Finance Officer to ensure that such persons are made aware of this and that contractual terms ensure the contractor and their employees comply with the same standards of governance and financial probity as would apply to any employee.

1.5. Amendment of Prime Financial Policies

1.5.1. To ensure that these Policies remain up-to-date and relevant, the Chief Finance Officer will review them at least annually. Following consultation with the Accountable Officer, review by the Finance and Performance Committee and scrutiny by the Audit and Governance Committee on behalf of the governing body, the Chief Finance Officer will recommend appropriate amendments to the governing body for approval. As an integral part of the constitution, any such amendment will not come into force until the group applies to the NHS England and that application is granted.

2. INTERNAL CONTROL

2.1. The Accountable Officer has overall responsibility for ensuring that the group has a suitable control environment and effective internal controls that provide reasonable assurance of effective and efficient operations, financial stewardship, probity and compliance with laws and policies.

2.2. The governing body has established an Audit and Governance Committee with terms of reference agreed by the governing body (see paragraph 6.9.5(a) of the constitution for further information).

2.3. The Chief Finance Officer will ensure that:

a) financial policies are considered for review and update annually;

b) a system is in place for proper checking and reporting of all breaches of financial policies; and

c) a proper procedure is in place for regular checking of the adequacy and effectiveness of the control environment.

3. AUDIT

3.1. The group will ensure that it has an effective and independent internal audit function and fully complies with Public Sector Internal Audit Standards and any other statutory reviews.

3.2. The Head of Internal Audit and the group's external auditor will have direct and unrestricted access to members of the Audit and Governance Committee, the Chair of the governing body, Accountable Officer and Chief Finance Officer for any significant issues arising from audit work that management cannot resolve, and for all cases of fraud or serious irregularity.

3.3. All members of the Audit and Governance Committee, the Chair of the governing body, the Accountable Officer and the Chief Finance Officer will have direct and unrestricted access to the Head of Internal Audit and external auditors.

3.4. The Chief Finance Officer will ensure that the Audit and Governance Committee approves any changes to the provision or delivery of assurance services to the group.

3.5. In line with the requirements of the Local Audit and Accountability Act 2014, the Group will appoint an Auditor Panel. In line with the requirement of the Act and subsequent regulations, the Panel will oversee and advise on the maintenance of an independent relationship between the group and its external auditor, and on the auditor's selection and appointment.

4. COUNTERING FRAUD AND CORRUPTION

4.1. The group has a zero tolerance approach to any lack of honesty, integrity or probity by employees or anyone with whom it does business in order to safeguard the public resources that they are responsible for. The group will not tolerate any fraud perpetrated against it and will actively chase any loss suffered. Any suspected fraud will be investigated professionally with commensurate sanctions applied if fraud is proven. The group will seek to recover any financial loss suffered provided that it is cost effective to do so.

4.2. The Audit and Governance Committee will satisfy itself that the group has adequate arrangements in place for countering fraud, approve the counter fraud work plan and review the outcomes of counter fraud work.

4.3. The Audit and Governance Committee will ensure that the group has suitable arrangements in place to work effectively with NHS Protect.

5. EXPENDITURE CONTROL

5.1. The group is required by statutory provisions[1] to ensure that its expenditure does not exceed the aggregate of allotments from NHS England and any other sums it has received and is legally allowed to spend.

5.2. The Accountable Officer has overall executive responsibility for ensuring that the group complies with certain of its statutory obligations, including its financial and accounting obligations and that it exercises its functions effectively, efficiently and economically.

5.3. The Chief Finance Officer will:

a) provide reports in the form required by NHS England ;

b) ensure money drawn from NHS England is required for approved expenditure only and is drawn down only at the time of need and follows best practice;

c) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the group to fulfil its statutory responsibility not to exceed its expenditure limits, as set by direction of NHS England.

6. ALLOTMENTS[2]

6.1. The Chief Finance Officer will:

a) periodically review the basis and assumptions used by NHS England for distributing allotments and ensure that these are reasonable and realistic and secure the group's entitlement to funds;

b) prior to the start of each financial year submit to the governing body for approval a report showing the total allotments received and their proposed distribution including any sums to be held in reserve; and

c) regularly update the governing body on changes to the initial allotment and the uses of such funds.

7. COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

7.1. The Accountable Officer will annually compile and submit to the governing body for approval a commissioning plan that explains how it proposes to discharge its financial duties and which takes into account financial targets, forecast limits of available resources and the results of consultation carried out in accordance with

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1 See section 223H of the 2006 Act, inserted by section 27 of the 2012 Act

2 See section 223(G) of the 2006 Act, inserted by section 27 of the 2012 Act.

the arrangements approved by the governing body[3]. The governing body will support this with comprehensive medium term plans and annual budget.

7.2. Prior to the start of each financial year the Chief Finance Officer will, on behalf of the Accountable Officer, prepare and submit budgets for approval by the governing body.

7.3. The Chief Finance Officer will monitor financial performance against the budgets and commissioning plan, periodically review them and prepare reports explaining significant variances based on any significant departures from agreed financial plans or budgets, for the Finance and Performance Committee and the governing body as required.

7.4. The approval of the governing body will be required for any changes to budgets significant enough to impact on the group's ability to meet its statutory duties and/or agreed strategic aims. Other changes will be approved by the Finance and Performance Committee.

7.5. The Accountable Officer has overall responsibility for ensuring that information relating to the group's accounts, its income or expenditure or its use of resources is provided to NHS England as requested.

8. ANNUAL ACCOUNTS AND REPORTS

8.1. The group will produce and submit to NHS England accounts and reports in accordance with all statutory obligations, relevant accounting standards and accounting best practice in the form and content and at the time required by NHS England.

8.2. The Chief Finance Officer will ensure that the group:

a) prepares a timetable for producing the annual report and accounts and agrees it with external auditors and the Finance and Performance Committee;

b) adheres to that timetable in preparing accounts in accordance with all statutory obligations[4], relevant accounting standards and accounting best practice in the form and content at the time required by NHS England;

c) complies with statutory requirements and relevant directions for the publication of an annual report;

d) considers the external auditor's management letter and fully addresses all issues within agreed timescales; and

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3 See section 14Z13 of the 2006 Act, inserted by section 26 of the 2012 Act

4 See paragraph 17 of Schedule 1A of the 2006 Act, as inserted by Schedule 2 of the 2012 Act.

publishes the external auditor's management letter on the group's website at www. www.wolverhamptonccg.nhs.uk. Alternatively, on request, a copy will be posted or sent by email to any enquirer who may wish to receive this.

9. INFORMATION TECHNOLOGY

9.1. The group will ensure the accuracy and security of its computerised financial data.

9.2. The Chief Finance Officer is responsible for the accuracy and security of the group's computerised financial data and will:

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the group's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 (as amended);

b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews, as the Chief Finance Officer may consider necessary, are being carried out.

9.3. In addition, the Chief Finance Officer will ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

10. ACCOUNTING SYSTEMS

10.1. The Chief Finance Officer will ensure:

a) the group has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of NHS England;

b) that contracts for computer services for accounting applications with another health organisation or any other agency clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage as well as ensuring the rights of access for audit purposes.

10.2. Where another health organisation or any other agency provides any accounting service to the group, the Chief Finance Officer will periodically seek assurances that adequate controls are in operation in line with the relevant auditing standards.

11. BANK ACCOUNTS

11.1. The Chief Finance Officer will:

a) review the banking arrangements of the group at regular intervals to ensure they are in accordance with Secretary of State directions[5], best practice and represent best value for money;

b) manage the group's banking arrangements and advise the group on the provision of banking services and operation of accounts;

c) prepare detailed instructions on the operation of bank accounts such that the group maintains sufficient liquidity to meet its current commitments .

11.2. The Finance and Performance Committee will approve the overall banking arrangements.

12. INCOME, CHARGES, SECURITY, GRANTS, LOANS AND INVESTMENTS

12.1. The Chief Financial Officer is responsible for:

a) designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due;

b) ensuring that the group maximises its potential to raise additional income but only to the extent that this does not interfere with the performance of the group or its functions[6];

c) approving and regularly reviewing the level of all fees and charges other than those determined by NHS England or by statute with independent professional advice on matters of valuation taken as necessary;

d) establishing and maintaining systems and procedures for the secure handling of cash or other negotiable instruments and ensuring the safe receipt of funds by electronic transfer;

e) developing effective arrangements for exercising the group’s powers to:

[5] See section 223H(3) of the NHS Act 2006, inserted by section 27 of the 2012 Act

[6] See section 14Z5 of the 2006 Act, inserted by section 26 of the 2012 Act.

i) make grants and loans to voluntary organisations which provide or arrange for the provision of similar services to those in respect of which CCGs have functions[7] with any such payments to be approved by the governing body;

ii) form or participate in forming a company and invest in and/or provide loans and guarantees and make other financial provision to the company, but only for the purpose of improving the physical and mental health of, and the prevention, diagnosis and treatment of illness in, the people for whom the CCG has responsibility. Any such arrangements will require the approval of the governing body.

13. TENDERING AND CONTRACTING

13.1. The group will ensure that competitive tenders, or quotes as appropriate, are invited for the supply of all goods and services or disposals of group assets when the nature of the expenditure/income and the likely value are such that competition is required by the group's detailed financial policies.

13.2. The Chief Finance Officer will ensure that any businesses/individuals invited to tender (or quote) and to whom any contract is be awarded have been subject to the checking and vetting procedures defined by the group's detailed financial policies.

13.3. The award of any contract will be approved as determined by the group's detailed financial policies and detailed scheme of delegation and documents will be signed on behalf of the group in accordance with Standing Order 6.

13.4. The group may only enter into contracts within the statutory framework set up by the 2006 Act, as amended by the 2012 & 2015 Acts. Such contracts will:

a) be consistent with the group's Standing Orders;

b) comply with the Public Contracts Regulation 2006, any successor legislation and any other applicable law; and

c) take into account as appropriate any applicable NHS England the Independent Regulator of NHS Foundation Trusts (Monitor) guidance that does not conflict with (b) above.

13.5. In all contracts entered into, the group will endeavour to obtain best value for money. The Accountable Officer has nominated the Chief Finance Officer to oversee and manage each contract on behalf of the group.

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[7] See section 14Z6 of the 2006 Act, inserted by section 26 of the 2012 Act.

14. COMMISSIONING

14.1. The group will coordinate its work as appropriate with NHS England , other clinical commissioning groups, local providers of services, local authority(ies), including through Health & Wellbeing Boards, patients and their carers, the voluntary sector and others to develop robust commissioning plans.

14.2. The group will enter into healthcare contracts in order to deliver its commissioning plans. This contracting activity will be subject to Prime Financial Policy 13 above, including the aspects relating to competition when the group chooses or is required to adopt a competitive approach to selecting its healthcare providers.

14.3. The group will maintain a register of procurement decisions that have been taken that will specify the decision, who was involved in making the decision and how any conflicts of interest that arose were dealt with.

14.4. The Accountable Officer will establish arrangements to ensure that regular reports are provided to the Finance and Performance Committee and governing body detailing actual and forecast expenditure and activity for each healthcare contract above the value specified in detailed Financial Policies, with similar reports presented to the Finance and Performance Committee for all healthcare contracts below that value.

14.5. The Chief Finance Officer will maintain a system of financial monitoring to ensure the effective accounting of expenditure under healthcare contracts. This will provide a suitable audit trail for all payments made under these contracts whilst maintaining patient confidentiality.

15. RISK MANAGEMENT, ASSURANCE AND INSURANCE

15.1. The group has arrangements in place such that the identification, analysis, evaluation and treatment of its risks are carried out in a systematic and consistent manner.

15.2. The group recognises that some level of risk is unavoidable in everything it seeks to do. The risk management policy approved by the Quality and Safety Committee describes its risk management philosophy, risk appetite and assigns the relevant responsibilities.

15.3. Any risk to the achievement of the group's strategic objectives are recorded and quantified in the group's Assurance Framework, for which the governing body is be responsible. The Framework describes the controls in place to manage these risks and the sources of assurance provided to the governing body that those controls are in place and effective. Action plans to address any risks or the decision to accept risks as assessed, are scrutinised by the Audit and Governance Committee which reports to the governing body.

15.4. Other risks are recorded and quantified in the group's Risk Register, for which the Quality and Safety Committee is responsible. The Register is populated by reference to incidents, complaints and contract non-compliances as well as management assessments of inherent risk. Action plans to address high-scoring risks, as required by the risk management policy, are endorsed by the Quality and Safety Committee so that the necessary actions can be approved in line with the relevant part of the group's constitution.

15.5. The Governing Body receives regular integrated assurance reports from both the Audit and Governance and Quality and Safety Committees on their work, which provide assurance on risk management arrangements and an opportunity to escalate any issues that arise. In addition, the Governing Body considers the Board Assurance Framework on a Quarterly basis to highlight and address any issues with the effectiveness of internal controls and the Risk Management arrangements and Assurance framework are subject to annual review and evaluation by Internal Audit.

15.6. The Chief Finance Officer shall decide if the CCG will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Chief Finance Officer decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers / third party liability) covered by the scheme this decision shall be reviewed annually by the Governing Body.

16. PAYROLL

16.1. The Chief Finance Officer will ensure that the payroll service selected:

a) is supported by appropriate contractual terms and conditions;

b) has adequate internal controls and audit review processes, as required by Prime Financial Policy 10;

c) has suitable arrangements for the collection of payroll deductions and payment of these to appropriate bodies.

16.2. In addition the Chief Finance Officer will set out comprehensive procedures for the group's effective submission of payroll data to the service provider and the receipt and use of output from them.

17. NON-PAY EXPENDITURE

17.1. The governing body will approve the level of non-pay expenditure on an annual basis (Prime Financial Policy 7.2) and the Accountable Officer will determine the level of delegation to budget managers through the detailed scheme of delegation.

17.2. The Chief Finance Officer will set out procurement procedures consistent with Prime Financial Policy 13 and covering the seeking of professional advice regarding the supply of goods and services.

17.3. The Chief Finance Officer will:

a) be responsible for the prompt payment of all properly authorised accounts and claims;

b) be responsible for a system of verification, recording and payment of all amounts payable;

c) ensure compliance with Prime Financial Policies 10 and 13 as relevant.

18. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

18.1. The Accountable Officer will

a) ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

b) be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

c) ensure that the capital investment is not undertaken without confirmation of the purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges;

d) be responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating and arranging for a physical check of assets against the asset register to be conducted once a year.

18.2. The Chief Finance Officer will prepare detailed procedures consistent with Prime Financial Policy 13 for disposals of the group's assets.

19. INFORMATION GOVERNANCE AND RETENTION OF RECORDS

19.1. The Accountable Officer will act as the group's Caldicott Guardian and:

a) be responsible for ensuring that the group retains or destroys all records in accordance with NHS Code of Practice: Records Management 2006 and other relevant notified guidance;

b) publish and maintain a Freedom of Information Publication Scheme and ensure that arrangements are in place for effective responses to Freedom of Information requests as required by the relevant legislation;

c) be responsible for ensuring that the group maintains compliance with all other relevant legislation including the Data Protection Act 1998 (as amended).

19.2 The Chief Finance Officer will act as the group's Senior Information Risk Owner.

19.3 Information governance policies to facilitate the above will be approved by the Quality and Safety Committee and the group will use the NHS Information Governance Toolkit in order to assess its performance in this area.

20. TRUST FUNDS

20.1. The Chief Finance Officer will ensure that the group does not hold any funds on trust, charitable or otherwise.

NHS WOLVERHAMPTON
CLINICAL COMMISSIONING GROUP

CONSTITUTION APPENDIX F

SCHEME OF RESERVATION AND DELEGATION

Version [4]

1. SCHEDULE OF MATTERS RESERVED TO THE CLINICAL COMMISSIONING GROUP AND SCHEME OF DELEGATION

1.1. The decision-making arrangements made by the group as set out in this Scheme of Reservation and Delegation of decisions shall have effect as if incorporated in the group's constitution.

1.2. The clinical commissioning group remains accountable for all of its functions, including those that it has delegated.

1.3. The table below indicates which decisions have been reserved to the group membership and these decisions can only be taken at a quorate meeting of the group itself, as described in the constitution and Standing Orders, or under 3.8.1 of Standing Orders in emergency or unforeseen circumstances.

1.4. Other decisions have been delegated to the governing body and these must be taken at a quorate meeting of that body, as described in the constitution and Standing Orders, or under 3.8.2 of Standing Orders in emergency or unforeseen circumstances.

1.5. Decisions delegated to the Accountable Officer or the Chief Finance Officer must be taken by the relevant individual or someone with express, written authority to do so on their behalf.

1.6. Decisions delegated to committees or sub-committees must be taken at a quorate meeting of that body, as described in the constitution, Standing Orders and the relevant terms of reference

Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Other Officer	Committee
Approval of applications to NHS England on any matter concerning changes to the group's constitution	✓				
Approval of the group's detailed scheme of delegation, setting out the key operational decisions delegated to individual employees of the group (and not deemed to be part of the constitution)		✓			
Approval of the delegation of powers to the group's joint committee with Wolverhampton City Council	✓				
Approval of the delegation of powers to representatives of the group under any joint or collaborative arrangements with other clinical commissioning groups		✓			
Approval of proposed changes to the Prime Financial Policies		✓			
Approval of the group's detailed financial policies (not deemed to be part of the constitution) and overall banking arrangements					**Finance and Performance**
Determination of detailed arrangements, consistent with its prime and detailed financial policies, under which the group will meet its general financial duties				**Chief Finance**	
Approval of the group's operating structure		✓			
Approval of the group's commissioning strategy, plans and policies, together with any arrangements for consultation thereon, and its procurement strategy		✓			
Approval of the group's budgets and any variations thereto which are significant enough to impact on the		✓			

Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Other Officer	Committee
group's ability to meet its statutory duties and/or agreed strategic aims					
Approval to award any contract of a higher value than that specified in Prime Financial Policy 13.3		✓			
Approval of budget variations not significant enough to impact on the group's ability to meet its statutory duties and/or agreed strategic aims					**Finance and Performance**
Approval of the group's annual report and annual accounts		✓			
Approval of terms and conditions, remuneration, fees and allowances for governing body members, including any pensions					**Remuneration**
Approval of arrangements by the group to form or participate in forming a company and invest in and/or provide loans and guarantees and make other financial provision to the company In addition, the governing body will consider recommendations to vary the Prime Financial Policies made to it by the AGC		✓			
Approval of terms and conditions, remuneration, fees, allowances and pensions payable to all employees and others providing services					**Remuneration**
Approval of grants and loans to voluntary organisations		✓			

Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Other Officer	Committee
Approval of human resources policies for employees and others working on behalf of the group, through which the group will discharge its statutory duties as an employer					**Remuneration**
Determination of arrangements for ensuring that the group meets the public sector equality duty and reduces inequalities in both access and outcomes			✓		
Determination of arrangements for securing public involvement, , promoting both awareness and use of the NHS Constitution, obtaining appropriate advice and promoting integration of services			✓		
Determination of arrangements for securing continuous improvement to the quality of commissioned services				**Executive Nurse**	
Determination of arrangements for supporting NHS England as regards improving the quality of primary medical services including quality and safety			✓		
Determination of arrangements for promoting the involvement of patients, their carers and representatives in decisions about their healthcare				**Executive Nurse**	
Determination of arrangements for enabling patients to make choices				**Executive Nurse**	
Determination of arrangements for promoting innovation, research, education and training				**Executive Nurse**	
Approval of policies for risk management including assurance, information governance, business continuity, emergency planning, security and complaints handling					**Quality and Safety**
Approval of action plans to address risks to the		✓			

Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Accountable Officer	Other Officer	Committee
achievement of strategic objectives or acceptance of the risk as currently assessed					
Determination of arrangements for internal audit and counter fraud services				**Chief Finance**	
Approval of internal audit and counter fraud plans and other arrangement for/sources of assurance through an integrated governance framework					**Audit and Governance**
Determination of arrangements for external audit services		✓			
Approval of business cases relating to new investments, new service developments or service increases within the overall operating plan or budgetary financial limit					**Commissioning**

NHS WOLVERHAMPTON
CLINICAL COMMISSIONING GROUP

CONSTITUTION

Version: [8]

NHS England Effective Date: 1 April 2017

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E	**Standing Orders**
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FOREWORD

NHS Wolverhampton Clinical Commissioning Group ('WCCG') aims to commission the highest quality, evidence-based care on behalf of its patients by investing in skills available locally and otherwise to design new and improved care pathways.

The clinical commissioning group will address health inequalities by being responsive to both patients and constituent practices. The engagement and support of its member practices will promote effective dialogue with providers aimed at bringing about the delivery of improved, cost effective health care.

WCCG will maintain a focus on health needs in Wolverhampton and commission cost effective services within the resources available.

The clinical commissioning group will adopt a culture in which individual practices engage in designing pathways and incorporate the needs of their practice population. The sum of these locally based approaches will help us to deliver our strategic commissioning objectives.

Practices will be supported through structured education and a quality improvement programme. This will help us to achieve common strategic objectives and standardise delivery of care for all of our patients.

The clinical commissioning group will share appropriate information with our constituent practices so that we can develop a better understanding of the needs in the locality for provision of different care patterns and the requirements of our constituent practices.

Appropriate governance mechanisms and information management tools will also be continuously developed. This will allow WCCG to share selective and essential data reflecting the achievements and shortcomings of the group, which can be shared with NHS England, the local authority public health function, Health and Wellbeing Board and – last but not least - patient groups.

The clinical commissioning group will maintain clear definitions and profiles for the roles and responsibilities of all governing body members and office holders. The corporate governance mechanisms will ensure that the Chair, Accountable Officer and all other Governing Body members have a clear brief. The objectives of all WCCG officers and Clinical Leads will be well defined through the Terms of Reference of our Committees and other documents and policies.

The clinical commissioning group works with third parties including the local authority and other statutory bodies in developing and implementing appropriate agreements in order to improve and develop local services. The group also works with NHS England to ensure that the services commissioned by it are an efficient and cost-effective part of the overall range of services available to the people of Wolverhampton.

Our focus will primarily be on maintaining and improving services for patients.

1. INTRODUCTION AND COMMENCEMENT

1.1. Name

1.1.1. The name of this clinical commissioning group is NHS Wolverhampton Clinical Commissioning Group.

1.2. Statutory Framework

1.2.1. Clinical commissioning groups are established under the Health and Social Care Act 2012 (“the 2012 Act”).[1] They are statutory bodies which have the function of commissioning services for the purposes of the health service in England and are treated as NHS bodies for the purposes of the National Health Service Act 2006 (“the 2006 Act”).[2] The duties of clinical commissioning groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act, and the regulations made under that provision.[3]

1.2.2. NHS England is responsible for determining applications from prospective groups to be established as clinical commissioning groups[4] and undertakes an annual assessment of each established group.[5] It has powers to intervene in a clinical commissioning group where it is satisfied that a group is failing, has failed to discharge any of its functions or there is a significant risk that it will fail to do so.[6]

1.2.3. Clinical commissioning groups are clinically-led membership organisations made up of general practices. The members of the clinical commissioning group are responsible for determining the governance arrangements for their organisations, which they are required to set out in a constitution.[7]

1.3. Status of this Constitution

1.3.1. This constitution has been approved by the members of NHS Wolverhampton Clinical Commissioning Group and has effect from 1 April 2015[8] The constitution is published on the group’s website at www.wolverhamptonccg.nhs.uk.

1.3.2. Copies of the constitution are available for inspection at the WCCG headquarters: Wolverhampton Science Park, Glaisher Drive, Wolverhampton WV10 9RU. Alternatively, on request, a copy will be posted or sent by email to any enquirer who may wish to receive this.

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1 See section 1I of the 2006 Act, inserted by section 10 of the 2012 Act
2 See section 275 of the 2006 Act, as amended by paragraph 140(2)(c) of Schedule 4 of the 2012 Act
3 Duties of clinical commissioning groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act
4 See section 14C of the 2006 Act, inserted by section 25 of the 2012 Act
5 See section 14Z16 of the 2006 Act, inserted by section 26 of the 2012 Act
6 See sections 14Z21 and 14Z22 of the 2006 Act, inserted by section 26 of the 2012 Act
7 See in particular sections 14L, 14M, 14N and 14O of the 2006 Act, inserted by section 25 of the 2012 Act and Part 1 of Schedule 1A to the 2006 Act, inserted by Schedule 2 to the 2012 Act and any regulations issued
8 See section 14D of the 2006 Act, inserted by section 25 of the 2012 Act

1.4. Amendment and Variation of this Constitution

1.4.1. This constitution can only be varied in two circumstances.[9]

a) where the group applies to NHS England and that variation is granted;

b) where in the circumstances set out in legislation, NHS England varies the group's constitution other than on application by the group.

2. AREA COVERED

2.1. The geographical area covered by NHS Wolverhampton Clinical Commissioning Group is the City of Wolverhampton.

3. MEMBERSHIP

3.1. Membership of the Clinical Commissioning Group

3.1.1. The practices listed in Appendix B comprise the members of NHS Wolverhampton Clinical Commissioning Group.

3.2. Eligibility

3.2.1. Providers of primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract will be eligible to apply for membership of this group[10].

4. MISSION, VISION, VALUES AND AIMS

4.1. Mission

4.1.1. The mission of NHS Wolverhampton Clinical Commissioning Group is:

> We will be an expert clinical commissioning organisation, working collaboratively with our patients, practices and partners across health and social care to ensure evidence-based, equitable, high quality and sustainable services for all of our population.

4.1.2. The group will promote good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

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9 See sections 14E and 14F of the 2006 Act, inserted by section 25 of the 2012 Act and any regulations issued

10 See section 14A(4) of the 2006 Act, inserted by section 25 of the 2012 Act and any regulations issued

4.2. Vision

4.2.1. Our vision is for the right care in the right place at the right time for all of our population. Our aim is to ensure that patients will experience seamless care, integrated around their needs, and they will live longer with improved quality of life.

4.3. Values

4.3.1. Good corporate governance arrangements are critical to achieving the group's objectives.

4.3.2. The values that lie at the heart of the group's work are:

a) to be a dynamic, responsive and innovative organisation;
b) to drive the commissioning agenda in Wolverhampton ;
c) to be a trusted and valued partner contributing positively to the health and social care economy;
d) to have a proactive, inclusive, equitable and professional approach that will secure best value for money and high quality in all that we do;
e) to be open and responsive to the local population, patients and clinicians;
f) to have ways of working that encourage people to want to work for and with us.

4.4. Aims

4.4.1. The group's aims are to:

a) improve and simplify arrangements for urgent care;
b) address variations in the quality of planned care;
c) improve the care of those with chronic conditions;
d) reduce health inequalities across Wolverhampton ;
e) commission the highest quality of services within available resources.

4.5. Principles of Good Governance

4.5.1. In accordance with section 14L(2)(b) of the 2006 Act,[11] the group will at all times observe "such generally accepted principles of good governance" in the way it conducts its business. These include:

a) the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;

b) *The Good Governance Standard for Public Services*;[12]

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[11] Inserted by section 25 of the 2012 Act

[12] *The Good Governance Standard for Public Services*, The Independent Commission on Good Governance in Public Services, Office of Public Management (OPM) and The Chartered Institute of Public Finance & Accountability (CIPFA), 2004

c) the standards of behaviour published by the *Committee on Standards in Public Life (1995)* known as the 'Nolan Principles'[13]

d) the seven key principles of the *NHS Constitution*;[14]

e) the Equality Act 2010.[15]

4.6. Accountability

4.6.1. The group will demonstrate its accountability to its members, local people, stakeholders and NHS England in a number of ways, including by:

a) publishing its constitution;

b) appointing independent lay members and non-GP clinicians to its governing body;

c) holding meetings of its governing body in public (except where the group considers that it would not be in the public interest in relation to all or part of a meeting);

d) publishing annually a commissioning plan;

e) complying with local authority health overview and scrutiny requirements;

f) meeting annually in public to publish and present its annual report (which must be published);

g) producing annual accounts in respect of each financial year which must be externally audited;

h) having a published and clear complaints process;

i) complying with the Freedom of Information Act 2000;

j) providing information to NHS England as required.

4.6.2. In addition to these statutory requirements, the group will demonstrate its accountability by:

a) making its principal commissioning policies available on its internet site;
b) holding public engagement events.

4.6.3. The governing body of the group will throughout each year have an ongoing role in reviewing the group's governance arrangements to ensure that the group continues to reflect the principles of good governance.

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13 See Appendix C

14 See Appendix D

15 See http://www.legislation.gov.uk/ukpga/2010/15/contents

5. FUNCTIONS AND GENERAL DUTIES

5.1. Functions

5.1.1. The functions that the group is responsible for exercising are largely set out in the 2006 Act, as amended by the 2012 Act. An outline of these appears in the Department of Health's Functions of clinical commissioning groups: a working document. They relate to:

a) commissioning certain health services (where NHS England is not under a duty to do so) that meet the reasonable needs of:
   i) all people registered with our member practices, and
   ii) people who are usually resident within our area and are not registered with a member of any clinical commissioning group;

b) commissioning emergency care for anyone present in our area;

c) meeting the costs of prescriptions written by our member practices;

d) paying our employees' remuneration, fees and allowances in accordance with the determinations made by the governing body and determining any other terms and conditions of service of the group's employees;

e) determining the remuneration and travelling or other allowances of members of our governing body.

5.1.2. In discharging its functions the group will:

a) act[16], when exercising its functions to commission health services, consistently with the discharge by the Secretary of State and NHS England of their duty to *promote a comprehensive health service*[17] and with the objectives and requirements placed on NHS England through *the mandate*[18] published by the Secretary of State before the start of each financial year, by:

   i) delegating responsibility for delivering this duty to the governing body;
   ii) establishing a Commissioning Committee to support the governing body in meeting that responsibility;
   iii) agreeing a Commissioning Policy consistent with this duty;
   iv) requiring our performance in delivery of this duty to be monitored by the Audit and Governance Committee.

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16 See section 3(1F) of the 2006 Act, inserted by section 13 of the 2012 Act

17 See section 1 of the 2006 Act, as amended by section 1 of the 2012 Act

18 See section 13A of the 2006 Act, inserted by section 23 of the 2012 Act

b) meet the *public sector equality duty*[19] by:

   i) delegating responsibility for delivering this duty to the Accountable Officer, who will discharge it using the Equality Delivery System toolkit;
   ii) agreeing an Equality and Diversity policy that, inter alia, requires all policies to be written with due regard for the group's responsibilities under the Equality Act 2010;
   iii) publishing at least annually sufficient information to demonstrate our compliance with this general duty across all our functions;
   iv) preparing, publishing and revising at least every four years our specific and measurable equality objectives;
   v) requiring our performance in delivery of this duty to be monitored by the Quality and Safety Committee.

c) work in partnership with our local authority to develop *joint strategic needs assessments*[20] and *joint health and wellbeing strategies*[21] by:

   i) ensuring that we are an effective member of the Wolverhampton Health and Wellbeing Board, on which we will be represented by an elected member of the governing body;
   ii) requiring our representatives on that Board to report to the governing body, as well as the Finance and Performance and Quality and Safety Committees as appropriate, with regard to development of the joint assessments and strategies and delivery of the latter;
   iii) delivering our duty under 5.2.13 below to integrate health services with health-related and social care services when appropriate to do so.

5.2. General Duties - in discharging its functions the group will:

5.2.1. Make arrangements to *secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements*[22] by:

a) delegating responsibility for delivering this duty to the Accountable Officer;
b) working in partnership with patients and the local community to secure the best care for them;
c) publishing information about health services on our website and adopting engagement activities that meet the specific needs of our different patient groups and communities;
d) ensuring that, as part of any of our processes for potential or actual changes to commissioning arrangements, there is appropriate consultation with or provision of information to the individuals for whom those changes could or would have an impact on the manner in which services are delivered to them or the range of services available to them;
e) encouraging and acting on feedback;

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19 See section 149 of the Equality Act 2010, as amended by paragraphs 184 and 186 of Schedule 5 of the 2012 Act

20 See section 116 of the Local Government and Public Involvement in Health Act 2007, as amended by section 192 of the 2012 Act

21 See section 116A of the Local Government and Public Involvement in Health Act 2007, as inserted by section 191 of the 2012 Act

22 See section 14Z2 of the 2006 Act, inserted by section 26 of the 2012 Act

f) thus delivering the *Statement of Principles* below;
g) requiring our compliance with this *Statement* to be monitored by the Quality and Safety Committee.

Statement of Principles

We will:

- commission high quality, patient-centred care;
- improve patient care by focussing on quality, including outcomes;
- adhere to evidenced based decision making;
- treat patients, carers and their representatives with respect;
- be open about what is possible, what cannot be changed and why;
- involve local people in decision making;
- respond to concerns and views and demonstrate how we have responded and what impact this has had;
- include those who are marginalised and considered 'hard to reach', by understanding our communities and stakeholders and valuing partnership working;
- undertake decision making in a fair way so that no group is significantly disadvantaged by the decisions we take;
- demonstrate a commitment to learning and development, exploring different ways of working and evaluating and implementing our learning for continual improvement.

5.2.2. *Promote awareness of, and act with a view to securing that health services are provided in a way that promotes awareness of, and have regard to the NHS Constitution*[23] by:

a) delegating responsibility for delivering this duty to the Accountable Officer, who will ensure that our arrangements for public engagement promote awareness of the *NHS Constitution*;
b) encouraging and supporting our constituent practices to provide health services in a manner that is consistent with this duty;
c) including within our Commissioning Policy a requirement to ensure that the health services we commission are provided in a manner that is consistent with this duty;
d) requiring our performance in delivery of this duty to be monitored by the Quality and Safety Committee.

5.2.3. Act *effectively, efficiently and economically*[24] by:

a) delegating responsibility for delivering this duty to the governing body;
b) establishing a Finance and Performance Committee to support the governing body in meeting that responsibility;

[23] See section 14P of the 2006 Act, inserted by section 26 of the 2012 Act and section 2 of the Health Act 2009 (as amended by 2012 Act)
[24] See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act

c) using our Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies as the policy framework through which this duty will be delivered;
d) requiring our performance in delivery of this duty to be monitored by the Audit and Governance Committee.

5.2.4. Act with a view to *securing continuous improvement to the quality of services*[25] by:

a) delegating responsibility for delivering this duty to the Executive Nurse, who will ensure that we are a learning organisation;
b) establishing a Commissioning Committee to support the Executive Nurse in meeting that responsibility;
c) including within our Commissioning and Contract Management Policies the requirement to ensure that services are commissioned and their delivery monitored in a manner that strives for continuous improvement in effectiveness, safety and quality;
d) requiring our performance in delivery of this duty to be monitored by the Quality and Safety Committee.

5.2.5. Assist and support NHS England in relation to its duty to *improve the quality of primary medical services*[26] by:

a) delegating responsibility for delivering this duty to the Accountable Officer;
b) agreeing with each of the constituent practices an Improving Quality of Primary Medical Services Policy that ensures the delivery of this duty in a manner so as to achieve a caring and responsible culture and environment;
c) requiring our performance in delivery of this duty to be monitored by the Quality and Safety Committee.

5.2.6. Have regard to the need to *reduce inequalities*[27] by:

a) delegating responsibility for delivering this duty to the Accountable Officer, who will discharge it in a manner consistent with our public sector equality duty at 5.1.2(b) above;
b) including within our Commissioning Policy the requirement to deliver our aim to reduce inequalities in patients' ability to access services and/or in the outcomes being delivered by the services they do use;
c) developing commissioning strategies and plans consistent with that policy requirement;
d) requiring our performance in delivery of this duty to be monitored by the Finance and Performance Committee.

25 See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act
26 See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act
27 See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act

5.2.7. *Promote the involvement of patients, their carers' and representatives in decisions about their healthcare*[28] by:

a) delegating responsibility for delivering this duty and those stated at b) to d) below to the Executive Nurse, who will be required to ensure its application with regard to prevention, diagnosis and treatment;
b) encouraging and supporting our constituent practices to provide health services in a manner that is consistent with this duty;
c) including within our Commissioning Policy a requirement to ensure that the health services we commission are provided in a manner that is consistent with this duty;
d) requiring our performance in delivery of this duty to be monitored by the Quality and Safety Committee.

5.2.8. Act with a view to *enabling patients to make choices*[29] by:

a) delegating responsibility for delivering this duty and those at b) to e) below to the Executive Nurse ;
b) encouraging and supporting our constituent practices to provide health services and refer patients to secondary health services in a manner that is consistent with this duty;
c) including within our Commissioning Policy a requirement to ensure that we commission services in a manner that is consistent with this duty;
d) including within our Commissioning Policy a requirement to ensure that the health services we commission are provided in a manner that is consistent with this duty;
e) requiring our performance in delivery of this duty to be monitored by the Quality and Safety Committee.

5.2.9. *Obtain appropriate advice*[30] from persons who, taken together, have a broad range of professional expertise in healthcare and public health by:

a) delegating responsibility for delivering this duty to the Accountable Officer, who will be required to ensure its application with regard to needs assessments, overall strategies and plans and any specific changes proposed for commissioning arrangements;
b) ensuring that, as part of any of our processes for potential or actual changes to commissioning arrangements, appropriate advice is obtained with regard to the relevant aspects of prevention, diagnosis and treatment of individual patients and/or the protection and improvement of public health in the community;
c) requiring our performance in achieving (b) above to be monitored by the Audit and Governance Committee.

5.2.10. *Promote innovation*[31] by:

a) delegating responsibility for delivering this duty to the Executive Nurse and providing he/she with support from other appropriate health professionals;

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28 See section 14U of the 2006 Act, inserted by section 26 of the 2012 Act
29 See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act
30 See section 14W of the 2006 Act, inserted by section 26 of the 2012 Act
31 See section 14X of the 2006 Act, inserted by section 26 of the 2012 Act

b) requiring the Executive Nurse to prepare an annual report to the governing body on how the group has promoted innovation in the provision of health services during the previous year.

5.2.11. *Promote research and the use of research*[32] by:

a) delegating responsibility for delivering this duty to the Executive Nurse and providing he/she with support from other appropriate health professionals;
b) requiring the Executive Nurse to prepare an annual report to the governing body on how the group has promoted relevant research and the use of evidence obtained from research during the previous year.

5.2.12. Have regard to the need to *promote education and training*[33] for persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England so as to assist the Secretary of State for Health in the discharge of his related duty[34] by:

a) delegating responsibility for delivering this duty to the Executive Nurse; and providing them with support from other appropriate health professionals;
b) requiring the Executive Nurse to prepare an annual report to the governing body on how the group has promoted relevant education and training during the previous year.

5.2.13. Act with a view to *promoting integration* of both health services with other health services and health services with health-related and social care services where the group considers that this would improve the quality of services or reduce inequalities[35] by:

a) delegating responsibility for delivering this duty to the Accountable Officer, who will be required to ensure consistency with the related duties at 5.1.2(c), 5.2.4 and 5.2.6 above;
b) requiring the Accountable Officer to prepare an annual report to the governing body on how the group has promoted integration in order to improve quality and reduce inequalities with regard to access to services and outcomes during the previous year.

5.3. General Financial Duties – the group will perform its functions so as to:

5.3.1. *Ensure its expenditure does not exceed the aggregate of its allotments for the financial year*[36] by

a) delegating responsibility for delivering this duty to the Chief Finance Officer;
b) establishing a Finance and Performance Committee to support the Chief Finance Officer in meeting that responsibility within a financial framework that gives priority to the quality of service provision;

32 See section 14Y of the 2006 Act, inserted by section 26 of the 2012 Act
33 See section 14Z of the 2006 Act, inserted by section 26 of the 2012 Act
34 See section 1F(1) of the 2006 Act, inserted by section 7 of the 2012 Act
35 See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act
36 See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act

c) using our Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies as the policy framework through which this duty will be delivered;
d) documenting accounting and budgetary control processes that enable all officers and employees of the group to comply with this policy framework;
e) requiring our performance in delivery of this duty to be monitored by the Audit and Governance Committee.

5.3.2. *Ensure its use of resources (both its capital resource use and revenue resource use) does not exceed the amount specified by NHS England for the financial year*[37] by

a) delegating responsibility for delivering this duty to the Chief Finance Officer;
b) establishing a Finance and Performance Committee to support the Chief Finance Officer in meeting that responsibility;
c) using our Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies as the policy framework through which this duty will be delivered;
d) documenting accounting, resource control and budgetary control processes that enable all officers and employees of the group to comply with this policy framework;
e) requiring our performance in delivery of this duty to be monitored by the Audit and Governance Committee.

5.3.3. *Take account of any directions issued by NHS England , in respect of specified types of resource use in a financial year, to ensure the group does not exceed an amount specified by NHS England* [38] by

a) delegating responsibility for delivering this duty to the Chief Finance Officer;
b) establishing a Finance and Performance Committee to support the Chief Finance Officer in meeting that responsibility;
c) using our Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies as the policy framework through which this duty will be delivered;
d) documenting accounting, resource control and budgetary control processes that enable all officers and employees of the group to comply with this policy framework;
e) requiring our performance in delivery of this duty to be monitored by the Audit and Governance Committee.

5.3.4. *Publish an explanation of how the group spent any payment in respect of quality* made to it by NHS England [39] by

a) delegating responsibility for delivering this duty to the Chief Finance Officer, who will be required to ensure that it is achievable by virtue of meeting the duties at 5.3.1 to 5.3.3 above

37 See sections 223I(2) and 223I(3) of the 2006 Act, inserted by section 27 of the 2012 Act
38 See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act
39 See section 223K(7) of the 2006 Act, inserted by section 27 of the 2012 Act

b) requiring the Chief Finance Officer to prepare an annual report to the governing body on how the group has spent any funds received from NHS England in respect of quality.

5.4. Other Relevant Regulations, Directions and Documents

5.4.1. The group will

a) comply with all relevant regulations;

b) comply with directions issued by the Secretary of State for Health or NHS England; and

c) take account, as appropriate, of documents issued by NHS England.

5.4.2. The group will develop and implement the necessary systems and processes to comply with these regulations and directions, documenting them as necessary in this constitution, its Scheme of Reservation and Delegation and other relevant group policies and procedures.

6. DECISION MAKING: THE GOVERNING STRUCTURE

6.1. Authority to act

6.1.1. The clinical commissioning group is accountable for exercising the statutory functions of the group. It may grant authority to act on its behalf to:

a) any of its members;

b) its governing body;

c) employees;

d) a committee or sub-committee of the group.

6.1.2. The extent of the authority to act of the respective bodies and individuals depends on the powers delegated to them by the group as expressed through:

a) the group's Scheme of Reservation and Delegation; and

b) for committees, their Terms of Reference.

6.2. Scheme of Reservation and Delegation[40]

6.2.1. The group's Scheme of Reservation and Delegation sets out:

a) those decisions that are reserved for the membership as a whole;

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40 See Appendix F

b) those decisions that are the responsibilities of its governing body (and its committees), the group's committees and sub-committees, individual members and employees.

6.2.2. The clinical commissioning group remains accountable for all of its functions, including those that it has delegated.

6.3. General

6.3.1. In discharging functions of the group that have been delegated to them, the governing body (and its committees), committees, joint committees, sub committees and individuals must:

a) comply with the group's principles of good governance,[41]

b) operate in accordance with the group's Scheme of Reservation and Delegation,[42]

c) comply with the group's Standing Orders,[43]

d) comply with the group's arrangements for discharging its statutory duties,[44]

e) where appropriate, ensure that member practices have had the opportunity to contribute to the group's decision making process.

6.3.2. When discharging their delegated functions, committees, sub-committees and joint committees must also operate in accordance with their approved terms of reference.

6.3.3. Where delegated responsibilities are being discharged collaboratively, the joint (collaborative) arrangements will:

a) identify the roles and responsibilities of those clinical commissioning groups who are working together and the responsibilities delegated by each group to the individuals representing them;

b) identify any pooled budgets and how these will be managed and reported in annual accounts;

c) specify under which clinical commissioning group's Scheme of Reservation and Delegation and supporting policies the collaborative working arrangements will operate;

d) specify how the risks associated with the collaborative working arrangement will be managed between the respective parties;

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41 See section 4.4 on Principles of Good Governance above
42 See Appendix F
43 See Appendix E
44 See chapter 5 above

e) identify how disputes will be resolved and the steps required to terminate the working arrangements;

f) specify how decisions are communicated to the collaborative partners.

6.4. Committees of the group and/or governing body

6.4.1. The group has not established any committees. The following committees have been established by the governing body:-

- The Audit and Governance Committee;
- Remuneration Committee;
- Quality and Safety Committee;
- Finance and Performance Committee; and
- Commissioning Committee
- Primary Care Commissioning Committee

6.4.2 Committees will only be able to establish their own sub-committees, to assist them in discharging their respective responsibilities, if this responsibility has been delegated to them by the group or governing body to which the committee is accountable and the group or governing body has approved the sub-committee's Terms of Reference.

6.5. Joint commissioning arrangements with other Clinical Commissioning Groups

6.5.1. The Group may wish to work together with other CCGs in the exercise of its commissioning functions.

6.5.2. The Group may make arrangements with one or more CCG in respect of:

a) delegating any of the Group's commissioning functions to another CCG;
b) exercising any of the commissioning functions of another CCG; or
c) exercising jointly the commissioning functions of the Group and another CCG

6.5.3. For the purposes of the arrangements described at paragraph 6.5.2, the Group may:

a) make payments to another CCG;
b) receive payments from another CCG;
c) make the services of its employees or any other resources available to another CCG; or
d) receive the services of the employees or the resources available to another CCG.

6.5.4. Where the Group makes arrangements which involve all the CCGs exercising any of their commissioning functions jointly, a joint committee may be established to exercise those functions.

6.5.5. For the purposes of the arrangements described at paragraph 6.5.2 above, the Group may establish and maintain a pooled fund made up of contributions by any of the CCGs working together pursuant to paragraph 6.5.3 above. Any such

pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.5.6. Where the Group makes arrangements with another CCG as described at paragraph 6.5.2 above, the Group shall develop and agree with that CCG an agreement setting out the arrangements for joint working, including details of:

a) How the parties will work together to carry out their commissioning functions;
b) The duties and responsibilities of the parties;
c) How risk will be managed and apportioned between the parties;
d) Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;
e) Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

6.5.7. The liability of the Group to carry out its functions will not be affected where the Group enters into arrangements pursuant to paragraph 6.5.2 above.

6.5.8. The Group will act in accordance with any further guidance issued by NHS England on co-commissioning.

6.5.9. Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.

6.5.10. The governing body of the Group shall require, in all joint commissioning arrangements, that the lead clinician and lead manager of the lead CCG make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

6.5.11. Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the Group can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the next new financial year.

6.6. Joint commissioning arrangements with NHS England for the exercise of CCG functions

6.6.1. The Group may wish to work together with NHS England in the exercise of its commissioning functions.

6.6.2. The Group and NHS England may make arrangements to exercise any of the Group's commissioning functions jointly.

6.6.3. The arrangements referred to in paragraph 6.62 above may include other CCGs.

6.6.4. Where joint commissioning arrangements pursuant to 6.6.2 above are entered into, the parties may establish a joint committee to exercise the commissioning functions in question.

6.6.5. Arrangements made pursuant to 6.6.2 above may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the Group.

6.6.6. Where the Group makes arrangements with NHS England (and another CCG if relevant) as described at paragraph 6.6.2 above, the Group shall develop and agree with NHS England a framework setting out the arrangements for joint working, including details of:

a) How the parties will work together to carry out their commissioning functions;
b) The duties and responsibilities of the parties;
c) How risk will be managed and apportioned between the parties;
d) Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;
e) Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements; and

6.6.7. The liability of the Group to carry out its functions will not be affected where the Group enters into arrangements pursuant to paragraph 6.6.2 above.

6.6.8. The Group will act in accordance with any further guidance issued by NHS England on co-commissioning.

6.6.9. Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.

6.6.10. The governing body of the Group shall require, in all joint commissioning arrangements that the Director of Strategy and Transformation make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

6.6.11. Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the Group can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months' notice period.

6.7. Joint commissioning arrangements with NHS England for the exercise of NHS England's functions

6.7.1. The Group may wish to work with NHS England and, where applicable, other CCGs, to exercise specified NHS England functions.

6.7.2. The Group may enter into arrangements with NHS England and, where applicable, other CCGs to:

a) Exercise such functions as specified by NHS England under delegated arrangements;
b) Jointly exercise such functions as specified with NHS England.

6.7.3. Where arrangements are made for the Group and, where applicable, other CCGs to exercise functions jointly with NHS England a joint committee may be established to exercise the functions in question.

6.7.4. Arrangements made between NHS England and the CCG may be on such terms and conditions (including terms as to payment) as may be agreed between the parties.

6.7.5. For the purposes of the arrangements described at paragraph 6.7.2 above, NHS England and the Group may establish and maintain a pooled fund made up of contributions by the parties working together. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.7.6. Where the Group enters into arrangements with NHS England as described at paragraph 6.7.2 above, the parties will develop and agree a framework setting out the arrangements for joint working, including details of:

a) How the parties will work together to carry out their commissioning functions;
b) The duties and responsibilities of the parties;
c) How risk will be managed and apportioned between the parties;
d) Financial arrangements, including payments towards a pooled fund and management of that fund;
e) Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

6.7.7. The liability of NHS England to carry out its functions will not be affected where it and the Group enter into arrangements pursuant to paragraph 6.7.2 above.

6.7.8. The Group will act in accordance with any further guidance issued by NHS England on co-commissioning.

6.7.9. Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.

6.7.10. The governing body of the Group shall require, in all joint commissioning arrangements that the Director of Strategy and Transformation make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

6.7.11. Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the Group can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months' notice period.

6.8. Joint Arrangements with the Local Authority

6.8.1. The group may form collaborative arrangements with Wolverhampton City Council in order to manage pooled budgets and make delegated decisions under Section 75 of the 2006 Act.

6.9. The Governing Body

6.9.1. *Functions* - the governing body has the following functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act, together with any other functions connected with its main functions as may be specified in regulations or in this constitution.[45] The governing body may also have functions of the clinical commissioning group delegated to it by the group. Where the group has conferred additional functions on the governing body connected with its main functions, or has delegated any of the group's functions to its governing body, these are set out from paragraph 6.9.1(d) below. The governing body has responsibility for:

a) ensuring that the group has appropriate arrangements in place to exercise its functions *effectively, efficiently and economically* (see 5.2.3 above) and in accordance with the group's *principles of good governance*[46] (its main function);

b) approving any functions of the group that are specified in regulations;[47]

c) leading the setting of vision and strategy, approving budgets and commissioning plans (Prime Financial Policy 7), monitoring performance against budgets, plans and contracts (PFP 14), providing assurance with regard to strategic risk management (PFP 15.3);

d) delivering the group's duty with regard to commissioning health services consistently with the duty of the Secretary of State and NHS England to promote a comprehensive health service and the objectives and requirements placed on NHS England through the Secretary of State's mandate (see 5.1.2(a) above);

e) approving the group's detailed scheme of delegation, operating structure, annual report and accounts, any grants and loans to voluntary organisations (PFP 12.1(e)(i));

f) agreeing changes to the terms of reference of its committees, other than with regard to membership, prior to their inclusion in an application to NHS England;

g) deciding to ratify any reported non-compliance with Standing Orders or upon the course of action required as a result of it (Standing Order 5).

6.9.2. *Composition of the Governing Body* - the governing body will comprise the following 16 members:

a) the chair, who will be an elected GP, appointed to a three year term (subject to re-election) by the members of the Governing Body

[45] See section 14L(3)(c) of the 2006 Act, as inserted by section 25 of the 2012 Act

[46] See section 4.4 on Principles of Good Governance above

[47] See section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act

b) other elected GPs, who shall be their practices representatives, such that the total number of members in 6.9.2 (a) and (b) is 8. 3 GPs will be elected by the localities (one from each locality) as the locality chairs responsible for formally representing their locality's views to the Governing Body. The remaining four GPs will be responsible for the clinical leadership of core areas including commissioning, quality and safety and finance and performance;

c) two lay members as defined by regulations, one of whom will chair the Remuneration Committee:

   i) one with qualifications, expertise or experience enabling them to express informed views about financial management, conflicts of interests and audit matters, who will chair the Audit and Governance Committee;
   ii) one who has knowledge about the City of Wolverhampton enabling them to express informed views about the discharge of the Group's functions, who will be deputy chair, the governing body lead for Equality and Diversity and Chair the Primary Care Commissioning Committee;

d) A lay member with knowledge of Finance and Performance matters who will chair the Finance and Performance Committee and act as deputy chair of the Primary Care Commissioning Committee.

e) one registered nurse who will be employed as the group's Executive Nurse;

f) one secondary care specialist doctor;

g) the Accountable Officer who will be employed as the group's Chief Officer and will act as the group's Caldicott Guardian;

h) the Chief Finance Officer, an individual with a recognised accountancy qualification who will be employed by the group and will act as the group's Senior Information Risk Owner;

i) the group's Director for Strategy and Transformation;

j) one practice manager representative.

The group's Standing Orders define how the group will, in accordance with any relevant regulations, appoint the various categories of members of the governing body, their tenure of office, how a person would resign from their post and the grounds for their removal from office. They also specify those persons who will be invited to attend meetings of the governing body as well as the arrangements for admission of the public and press.

6.9.3 **The Locality Boards**

Functions - the Locality Boards covering North East, South East and South West Wolverhampton are to be established as advisory Boards only and regulated by their terms of reference which shall initially have the following functions, (which may alter from time to time as reflected in their terms of reference to be

determined by the governing body). The Locality Board(s) may also have functions of the group delegated to it by the governing body. The Locality Boards have responsibility for:

a) ensuring that the localities have appropriate arrangements in place to exercise their functions *effectively, efficiently and economically* (see 5.2.3 above) and in accordance with the group's *principles of good governance*[48];

b) helping the governing body in leading the setting of vision and strategy and commissioning plans (Prime Financial Policy 7), monitoring performance against budgets, plans and contracts (PFP 14) and providing assurance with regard to strategic risk management (PFP 15.3);

c) helping the governing body in delivering the group's duty with regard to commissioning health services consistently with the duty of the Secretary of State and NHS England to promote a comprehensive health service and the objectives and requirements placed on NHS England through the Secretary of State's mandate (see 5.1.2(a) above);

d) representing the views of local people and practices in order to develop locally sensitive services, thereby creating local ownership of the Group's vision and values;

e) promoting a sense of locality and care closer to home in a patient-centred way

f) helping to promote high quality primary care via quality monitoring and peer support in a facilitative way via mentoring, buddying and practical support.

6.9.4 *Composition of the Locality Boards* – when established the locality boards will be comprised of the nominated representatives from each practice and the group's support staff

a) the chair, will be a democratically elected by the locality to a three year term by the GP members across the locality
b) the Chair will be supported by the group's management staff, namely,
   - the finance lead;
   - data and informatics lead;
   - quality lead; and
   - other staff as necessary;
c) practice representatives either GP or other healthcare professional.

6.9.5 *Committees of the Governing Body* - the governing body has appointed the following committees:

(a) the *Audit and Governance Committee*, which is accountable to the governing body and provides it with an independent and objective view of the group's financial systems, financial information and compliance with laws, regulations and directions governing the group, so far as they relate to finance

48 See section 4.4 on Principles of Good Governance above

and governance. The governing body has approved and annually reviews the terms of reference for the committee, which include information on its membership[49]. In addition the group or the governing body has conferred upon or delegated the following functions, connected with the governing body's main function[50], to the Audit and Governance Committee:

i) reviewing the group's adherence to the generally accepted principles of good governance (4.4.1 above);
ii) monitoring the group's performance in delivering the duty to act effectively, efficiently and economically (5.2.3 above);
iii) monitoring the group's performance in the delivery of the duties described at 5.1.2(a), 5.2.9 and the general financial duties at 5.3.1 – 5.3.3;
iv) reviewing the reasonableness of any decision to suspend Standing Orders (SO 3.9), considering reports on non-compliance with Prime Financial Policies (PFP 1.2.1) and scrutinising any proposed changes thereto (PFP 1.5.1);
v) reviewing the group's arrangements to manage all risks and receive appropriate assurance thereon through an integrated governance framework[51];
vi) satisfying itself that there is an effective internal audit service (PFP 3) and adequate arrangements for countering fraud (PFP 4), reviewing the work and findings of the external auditors, approving any changes to the provision or delivery of assurance services (PFP 3.4 (b));
vii) reviewing the annual report and financial statements before submission to the governing body and group.

(b) the *Remuneration Committee*, which is accountable to the governing body and makes binding and final determinations about the remuneration, fees and other allowances for employees and for people who provide services to the group and on determinations about allowances under any pension scheme that the group may establish as an alternative to the NHS pension scheme. The governing body has approved and keeps under review the terms of reference for the committee, which include information on its membership[52]. In addition, the group or the governing body has conferred or delegated the following functions, connected with the governing body's main function, to the Remuneration Committee:

i) determining the remuneration, fees and other allowances payable to group and governing body members, employees or other persons providing services to the group, including the remuneration and conditions of service of the senior team and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act;
ii) determining the performance, remuneration and terms and conditions of the Accountable Officer and other senior team members and determining annual salary awards, if appropriate.

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49 See Appendix H1 Terms of Reference of the Audit and Governance Committee

50 See section 14L(2) of the 2006 Act, inserted by section 25 of the 2012 Act

51 NHS Audit Committee Handbook, Department of Health / Healthcare Financial Management Association, 2011

52 See Appendix H2 Terms of Reference of the Remuneration Committee

iii) considering any severance payments of the Accountable Officer and other senior staff, seeking HM Treasury approval as appropriate in accordance with the guidance 'Managing Public Money' (available on the HM Treasury.gov.uk website);
iv) approving human resources policies (9.4 below);and ,
v) approving the group's terms and conditions and remuneration of employees and those providing services to the group.

(c) the *Quality and Safety Committee,* which is accountable to the governing body and provides it with assurance on the quality of services commissioned and monitors on its behalf the group's performance in the delivery of the duties described at 5.1.2(b), 5.2.1, 5.2.2, 5.2.4, 5.2.5, 5.2.7 and 5.2.8. The governing body has approved and keeps under review the terms of reference for the committee, which include information on its membership[53]. In addition the group or the governing body has conferred or delegated the following functions, connected with the governing body's main function, to the Quality and Safety Committee:

i) receiving reports from the group's representative on the Wolverhampton Health and Wellbeing Board (see 5.1.2 (c)(ii) above);
ii) approving policies for risk management including assurance (Prime Financial Policy 15.2), information governance (PFP 19.2), business continuity, emergency planning , security and complaints handling;
iii) endorsing action plans to address high scoring risks in the group's risk register (PFP 15.4).

d) the *Finance and Performance Committee,* which is accountable to the governing body and provides it with assurance on issues related to the finances and performance of the group and monitors on its behalf the group's performance in the delivery of the duties described at 5.2.3 and 5.2.6. The governing body has approved and keeps under review the Terms of Reference for the committee, which include information on its membership[54]. In addition the group or the governing body has conferred or delegated the following functions, connected with the governing body's main function, to the Finance and Performance Committee:
i) supporting the Chief Finance Officer in the delivery of the general financial duties (5.3.1 -5.3.3 above);
ii) receiving reports from the group's representative on the Wolverhampton Health and Wellbeing Board (see 5.1.2 (c)(ii) above);
iii) reviewing proposed changes to Prime Financial Policies (PFP 1.5.1) and approving detailed financial policies (PFP 1.1.3);
iv) considering reports from the Chief Finance Officer and other managers regarding significant variances from budgeted performance (PFP7.3) and planned performance targets respectively;
v) agreeing the timetable for producing the annual accounts and report (PFP8.1(a));
vi) approving the group's overall banking arrangements (PFP 11.2);

[53] See Appendix H3 Terms of Reference of the Quality and Safety Committee
[54] See Appendix H4 Terms of Reference of the Finance and Performance Committee

vii) receiving reports detailing actual and forecast expenditure and activity for all healthcare contracts (PFP 14.3).

e) the *Commissioning Committee*, which is accountable to the governing body and will support it, the Director of Strategy and Transformation and the Executive Nurse in meeting the responsibilities of the group as a commissioner of healthcare, specifically delivery of the duties described at 5.1.2(a) and 5.2.4. The governing body has approved and keeps under review the Terms of Reference for the committee, which include information on its membership[55]. In addition the group or the governing body has conferred or delegated the following functions, connected with the governing body's main function, to the Commissioning Committee:

i) developing appropriate policies, strategies and plans;
ii) co-ordinating the work of the group with other parties in order to develop robust commissioning plans (PFP 14.1).

f) the *Primary Care Commissioning Committee,* which is accountable to the governing body for the exercise of the functions delegated to the group by NHS England relating to the commissioning of primary medical services under Section 86 of the NHS Act 2006.

7. ROLES AND RESPONSIBILITIES

7.1. Practice Representatives

7.1.1. Practice representatives will be GPs or other healthcare professionals who represent their practice's views and act on behalf of the practice in matters relating to their specific locality and the group as a whole. The role of each practice representative is to assist the group in securing the effective participation of each member of the group in exercising the group's functions by:

a) providing effective liaison between the practice and the rest of the locality and group;
b) promoting the work of the locality and group within the practice and to its patients as far as possible;
c) actively seeking the views of the practice and its patients and providing feedback to the rest of the locality and group;
d) arranging for the implementation of agreed locality and group directives within the practice or informing the rest of the locality and group as soon as possible of any obstacles to doing so;
e) attending meetings of the locality and group so that the practice is represented and its voice heard, or ensuring that a deputy does so.

Details as to how practice representatives will be selected are included in the group's Standing Orders, which also specify the officer of the group that practices must inform as to who their representative is.

7.2. Other GPs and Primary Care Health Professionals

55 See Appendix H5 Terms of Reference of the Commissioning Committee

7.2.1. In addition to the practice representatives identified in section 7.1 above, the group has identified a number of other GPs/primary care health professionals from member practices to support the work of the group and/or represent the group rather than represent their own individual practices. These GPs and primary care health professional undertake the following roles on behalf of the group, reporting in each case to the member of the governing body with responsibility for the particular work area:

a) developing proposals for changes to care pathways;
b) developing proposals for other significant changes to the group's commissioning portfolio;
c) monitoring a provider's delivery against its contract with the group in terms of activity or quality;
d) liaising with practices and consulting with patients/carers in support of these activities;
e) education and research in support of these activities.

7.3. All Members of the Group's Governing Body

7.3.1. Guidance on the roles of members of the group's governing body is set out in a separate document[56]. In summary, each member of the governing body should share responsibility as part of a team to ensure that the group exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of this constitution. Each brings their unique perspective, informed by their expertise and experience.

7.3.2. All members will be able to demonstrate the leadership skills necessary to fulfil the responsibilities of these key roles and establish credibility with all stakeholders and partners. Especially important is that the governing body remains in tune with the group's member practices and secures their confidence and engagement.

7.4. The Chair of the Governing Body

7.4.1. The Chair of the governing body is responsible for:

a) leading the governing body, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this constitution;

b) building and developing the group's governing body and its individual members;

c) ensuring that the group has proper constitutional and governance arrangements in place;

d) ensuring that, through the appropriate support, information and evidence, the governing body is able to discharge its duties;

e) supporting the accountable officer in discharging the responsibilities of the organisation;

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56 *Clinical commissioning group Governing Body Members – Role outlines, Attributes and Skills,* NHS Commissioning Board , October 2012

f) contributing to building a shared vision of the aims, values and culture of the organisation;

g) leading and influencing to achieve clinical and organisational change to enable the group to deliver its commissioning responsibilities;

h) overseeing governance and particularly ensuring that the governing body and the wider group behaves with the utmost transparency and responsiveness at all times;

i) ensuring that public and patients' views are heard and their expectations understood and, where appropriate as far as possible, met;

j) ensuring that the organisation is able to account to its local patients, stakeholders and NHS England;

k) ensuring that the group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from Wolverhampton City Council.

7.5. The Deputy Chair of the Governing Body

7.5.1. The Deputy Chair of the governing body deputises for the Chair of the governing body where he or she has a conflict of interest or is otherwise unable to act.

7.5.2. Details of how they will be appointed, their tenure of office and resignation or removal are included in the group's Standing Orders.

7.6. Role of the Accountable Officer

7.6.1. The Accountable Officer of the group is a member of the governing body.

7.6.2. This role of Accountable Officer has been summarised in a national document[57] and this is reflected in (a) to (c) below:

a) being responsible for ensuring that the clinical commissioning group fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money;

b) at all times ensuring that the regularity and propriety of expenditure is discharged and that arrangements are put in place to ensure that good practice (as identified though the relevant agencies and, in particular, the auditors of the group) is embodied and that safeguarding of funds is ensured through effective financial and management systems;

[57] See the latest version of the NHS Commissioning Board Authority's *Clinical commissioning group governing body members: Role outlines, attributes and skills*

c) working closely with the Chair of the governing body, the Accountable Officer will ensure that proper constitutional, governance and development arrangements are put in place to assure the members (through the governing body) of the organisation's ongoing capability and capacity to meet its duties and responsibilities. This will include arrangements for the ongoing developments of its members and staff.

d) the group has specifically delegated responsibility to the Accountable Officer for the delivery of its duties as described at 5.1.2(b), 5.2.1, 5.2.2, 5.2.5, 5.2.6 and 5.2.8 and for the role of Caldicott Guardian.

7.7. Role of the Chief Finance Officer

7.7.1. The Chief Finance Officer is a member of the governing body and is responsible for providing financial advice to the clinical commissioning group and for supervising financial control and accounting systems.

7.7.2. This role of the Chief Finance Officer has been summarised in a national document[58] and this is reflected in (a) to (e) below:

a) being the governing body's professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged;

b) making appropriate arrangements to support, monitor and report on the group's finances;

c) overseeing robust audit and governance arrangements leading to propriety in the use of the group's resources;

d) being able to advise the governing body on the effective, efficient and economic use of the group's allocation to remain within that allocation and deliver required financial targets and duties; and

e) producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to NHS England;

f) the group has accordingly delegated responsibility to the Chief Finance Officer for the delivery of its financial duties described at 5.3 above and as the Senior Information Risk Owner.

7.8. Joint Appointments with other Organisations

7.8.1. The group has not yet made any joint appointments with other organisations.

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[58] See the latest version of the NHS Commissioning Board Authority's *Clinical commissioning group governing body members: Role outlines, attributes and skills*

7.9. Responsibilities of member practices to the group and of the group to its member practices

7.9.1. The group is a membership organisation and the effective participation of each and every member practice will be essential in developing and sustaining cost effective commissioning arrangements that ensure high quality services for all relevant patients and service users.

7.9.2. Each member practice will:

a) appoint a practice representative in line with 7.1 above and Standing Order 2.2.5;

b) undertake regular, at least quarterly, practice meetings to monitor performance against the commissioning indicators as set out in the group's commissioning performance reports;

c) meet with the relevant locality chair and/or GP engagement lead and agree plans to support delivery of the group's commissioning strategies;

d) support the relevant locality board and group's commissioning intentions and strategies by using, as appropriate and in accordance with patient choice, services and pathways as commissioned by the group;

e) access relevant commissioning information including that relating to pathways and referral guidelines via agreed group systems;

f) take all reasonable efforts to ensure that it remains within its commissioning budget;

g) support the relevant, locality board and the group in meeting its quality and productivity targets as set out within the group's commissioning strategies;

h) take account of all duties, rights, pledges and values set out in this constitution;

i) respond in a timely manner to reasonable information requests from the group.

7.9.3. The group will ensure that:

a) all member practices receive at least one visit each year from representatives of the group to discuss practice level commissioning issues and priorities;

b) an annual survey of practices, designed and administered in conjunction with the Local Medical Committee (LMC), is undertaken to obtain feedback on levels of satisfaction regarding practice involvement in the commissioning process;

c) member practices are kept informed of group business via their practice representatives and relevant locality board chair, the intranet site, specific events and other appropriate means;

d) the governing body provides information management tools, training and support to enable member practices to review information at patient level and support them in meeting their financial and quality targets.

7.10. Dispute Resolution Processes

7.10.1. This process will be used promptly, in a supportive and constructive manner, in the event of any dispute or disagreement being raised by:

a) member practices, regarding the governing body or general workings of the group;
b) the governing body and/or the rest of the group in relation to the behaviour of any member practice.

7.10.2. Member practices should, in the normal course of events, be able to raise any contentious issue with their relevant locality board chair or deputy chair, or if this is not possible, with another member of the governing body. In circumstances where this informal contact does not resolve the issue satisfactorily, the following process will be followed:

a) the practice will set out the issue in writing and submit this to the Accountable Officer;

b) the Accountable Officer will acknowledge receipt within ten working days unless the issue appears extremely urgent, in which case, the matter will be progressed with the utmost urgency;

c) the Chair and/or Accountable Officer will contact the practice to discuss the matter, involving those with relevant lead responsibilities within the group as appropriate, and agree in writing appropriate actions for resolution with a time-scale for actions by all involved parties;

d) if this fails to resolve the issue, the matter will be referred to a lay member of the governing body, who will be responsible for leading consideration of the matter in private session at a governing body meeting to which the practice will be able to make direct representation of its position and at which appropriate actions for resolution will be minuted;

e) if the matter still cannot be resolved, it will be referred by the member practice and/or the governing body to NHS England for a binding arbitration;

f) a member practice can involve the LMC or other external support, except legal representation, at any stage of this process.

7.10.3. In the normal course of events, any issues regarding a member practice's non-compliance with its responsibilities as a member of the group will be raised via routine reporting arrangements and discussion with the relevant locality board

chair. When such issues cannot be resolved via this normal day to day contact, the following process will be followed:

a) on behalf of the governing body, the Chair of the governing body or Accountable Officer will set out the issue in writing and send this to the member practice;

b) the practice will acknowledge receipt within ten working days unless the issue appears extremely urgent, in which case, the matter will be progressed with the utmost urgency

c) the practice will be asked to meet with the Chair of the governing body and/or Accountable Officer to discuss the issue, involving those with relevant lead responsibilities within the group as appropriate, and put in writing appropriate actions against an agreed timescale;

d) the group will ensure that the member practice is provided with the appropriate information and assistance to support it in delivering the agreed plan;

e) if this approach fails to resolve the issue or the practice fails to deliver the actions agreed to address the non-compliance to the satisfaction of the governing body (meeting in private), the issue will be escalated to NHS England whose decision on the matter will be final;

f) a member practice can involve the LMC or other external support, except legal representation, at any stage of this process.

8. STANDARDS OF BUSINESS CONDUCT AND MANAGING CONFLICTS OF INTEREST

8.1. Standards of Business Conduct

8.1.1. Employees, members, committee and sub-committee members of the group and members of the governing body and its committees will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should act in good faith and in the interests of the group and should follow the Seven Principles of Public Life, set out by the Committee on Standards in Public Life (the Nolan Principles) The Nolan Principles are incorporated into this constitution at Appendix C.

8.1.2. They must comply with the group's policy on business conduct, including the requirements set out in the policy for meeting the group's duties with regard to registering interests and managing conflicts of interest.[59] This policy will be available on the group's website at www.wolverhamptonccg.nhs.uk, available for inspection at the group's offices, and either by post or email on request.

[59] In accordance with Section 14O of the 2006 Act, inserted by Section 25 of the 2012 Act

8.1.3. Individuals contracted to work on behalf of the group or otherwise providing services or facilities to the group will be made aware of their obligation with regard to declaring actual or potential conflicts of interest. This requirement will be written into their contract for services.

8.1.4. Due consideration will be given to the available guidelines, protocols and the manner in which conflicts of interest are managed by statutory bodies, recognised national institutions such as the General Medical Council, General Practitioners Committee of the British Medical Association and, the Royal College of General Practitioners , and if appropriate, the group's policy amended from time-to-time to reflect these.

8.2. Conflicts of Interest

8.2.1. As required by section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act, the group has made arrangements to manage actual and potential conflicts of interest to ensure that decisions made by the group will be taken and be seen to be taken without any possibility of the influence of external or private interest; the group maintains a register recording these

8.2.2. Where an individual, i.e. an employee, group member, member of the governing body, or a member of a committee or a sub-committee of the group or its governing body has an interest, or becomes aware of an interest, which could lead to a conflict of interest in the event of the group considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this constitution.

8.2.3. A conflict of interest will include:

a) **Financial Interests**: where an individual or somebody with whom they have a close association may financially benefit from the consequences of a commissioning decision (for example, as a provider of services);

b) **Non- Financial Professional Interests –** where an individual or somebody with whom they have a close association may obtain a non-financial professional benefit from the consequences of a group decision, such as increasing their professional reputation or status or promoting their professional career;

c) **Non-Financial Personal Interests** – where an individual or somebody with whom they have a close association may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house);;

8.2.4. If in doubt, the individual concerned should assume that a potential conflict of interest exists and notify the CCG's Governance Lead or Conflicts of Interest Guardian (The Chair of the Audit and Governance Committee)accordingly.

8.3. Declaring and Registering Interests

8.3.1. The group will maintain one or more registers of the interests of:

a) the members of the group;

b) the members of its governing body;

c) the members of its committees or sub-committees and the committees or sub-committees of its governing body; and

d) its employees.

8.3.2. The registers are to be published on the group's website at www.wolverhamptonccg.nhs.uk. Upon request, these will also be available at the group's Head Office or, on application by post or email.

8.3.3. Individuals will declare any interest that they have, in relation to a decision to be made in the exercise of the commissioning functions of the group, in writing to the governing body, as soon as they are aware of it and in any event no later than 28 days after becoming aware.

8.3.4. Where an individual is unable to provide a declaration in writing, for example, if a conflict becomes apparent in the course of a meeting, they will make an oral declaration before witnesses, and provide a written declaration as soon as possible thereafter.

8.3.5. The Conflict of Interest Guardian will ensure that the registers of interest are reviewed quarterly, and updated as necessary.

8.3.6. Prior to any appointment being made to the Governing Body, individuals will make a declaration of their interests in order to assess whether any identified conflicts would prevent the individual concerned making a full and proper contribution to the governing body. If such significant conflicts do exist, the individual concerned will be excluded from the appointment process.

8.4. Managing Conflicts of Interest: general

8.4.1. Individual members of the group, the governing body, committees or sub-committees, the committees or sub-committees of its governing body and employees will comply with the arrangements determined by the group for managing actual or potential conflicts of interest.

8.4.2. The Conflict of Interest Guardian will ensure that for every interest declared, either in writing or by oral declaration, arrangements are in place to manage the conflict of interests or potential conflict of interests, to ensure the integrity of the group's decision making processes.

8.4.3. Arrangements for the management of conflicts of interest are to be determined by the lay member identified at 8.3.5 and will include the requirement to put in writing to the relevant individual arrangements for managing the actual or potential conflict within a week of declaration. The arrangements will confirm the following:

a) when an individual should withdraw from a specified activity, on a temporary or permanent basis;

b) monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.

8.4.4. Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity connected with the group's exercise of its commissioning functions, they have received confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the Conflict of Interest Guardian.

8.4.5. Where an individual member, employee or person providing services to the group is aware of an interest which:

a) has not been declared, either in the register or orally, they will declare this at the start of the meeting;

b) has previously been declared, in relation to the scheduled or likely business of the meeting, the individual concerned will bring this to the attention of the chair of the meeting, together with details of arrangements which have been confirmed for the management of the actual or potential conflict of interest(s);

The chair of the meeting will then determine how this should be managed and inform the member of their decision. Where no arrangements have been confirmed, the chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual will then comply with these arrangements, which must be recorded in the minutes of the meeting. The Chair's determination in relation to action to be taken in relation to a conflict arising, shall be final.

8.4.6. Where the chair of any meeting of the group, including committees, sub-committees, or the governing body and the governing body's committees and sub-committees, has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the deputy chair will act as chair for the relevant part of the meeting. Where arrangements have been confirmed for the management of the actual or potential conflict of interest in relation to the chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the deputy chair may require the chair to withdraw from the meeting or part of it. Where there is no deputy chair, the members of the meeting will select one.

8.4.7. Any declarations of interests, and arrangements agreed in any meeting of the clinical commissioning group, committees or sub-committees, or the governing

body, the governing body's committees or sub-committees, will be recorded in the minutes.

8.4.8. Where more than 50% of the members of a meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of actual or potential conflicts of interest, the chair (or deputy) will determine whether or not the discussion can proceed.

8.4.9. In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the group's Standing Orders. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum could never be convened from the membership of the meeting, owing to the arrangements for managing actual or potential conflicts of interest, the chair of the meeting will consult with the lay member identified at 8.3.5 on the action to be taken.

8.4.10. This action might include:

a) referring the matter to the group's governing body, its committees or sub-committees , which can be quorate to progress the item of business even if all the elected members and/or other members have to be excluded from voting (Standing Order 3.6.2);

b) inviting, on a temporary basis, one or more of the following to make up the quorum, i.e. those who do not have a conflict of interest, to attend the relevant part of the governing body's meeting to provide additional scrutiny to the matter and advice to those members of the governing body who can vote on it:

   i) a practice representative; and/or
   ii) an individual appointed by a member to act on his/her behalf in the dealing between it and the group
   iii) a member of a relevant Health and Wellbeing Board;
   iv) a member of a governing body of another clinical commissioning group.

These arrangements must be recorded in the relevant minutes.

8.4.11. In any transaction undertaken in support of the clinical commissioning group's exercise of its commissioning functions (including conversations between two or more individuals, e-mails, correspondence and other communications), individuals must ensure, where they are aware of an interest, that they conform to the arrangements confirmed for the management of that interest. Where an individual has not had confirmation of arrangements for managing the interest, they must declare their interest at the earliest possible opportunity in the course of that transaction, and declare that interest as soon as possible thereafter. The individual must also inform either their line manager (in the case of employees), or the lay member identified at 8.3.5 of the transaction.

8.4.12. The Conflict of Interest Guardian will take such steps as deemed appropriate, and request information deemed appropriate from individuals, to ensure that all actual and potential conflicts of interest are declared and recorded.

8.5. Managing Conflicts of Interest: contractors and people who provide services to the group

8.5.1. Anyone seeking information in relation to a procurement, or participating in a procurement, or otherwise engaging with the clinical commissioning group in relation to the potential provision of services or facilities to the group, will be required to make a declaration of any relevant actual or potential conflict of interest.

8.5.2. Anyone contracted to provide services or facilities directly to the clinical commissioning group will be subject to the same provisions of this constitution in relation to managing conflicts of interests. This requirement will be set out in the contract for their services.

8.6. Transparency in Procuring Services

8.6.1. The group recognises the importance in making decisions about the services it procures in a way that does not call into question the motives behind the procurement decision that has been made. The group will procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers, using special designated procedures when GPs or their practices are potential providers or have an interest therein.

8.6.2. The group will publish a Procurement Strategy approved by its governing body which will ensure that:

a) all relevant clinicians (not just members of the group) and potential providers, together with local members of the public, are engaged in the decision-making processes used to procure services;

b) service redesign and procurement processes are conducted in an open, transparent, non-discriminatory and fair way

8.6.3. Copies of this Procurement Strategy will be available on the group's website at www.wolverhamptonccg.nhs.uk, available for inspection at the group's offices, and either by post or email, on request.

9. THE GROUP AS EMPLOYER

9.1. The group recognises that its most valuable asset is its people. It will seek to enhance their skills and experience and is committed to their development in all ways relevant to the work of the group.

9.2. The group will seek to set an example of best practice as an employer and is committed to offering all staff equality of opportunity. It will ensure that its

employment practices are designed to promote diversity and to treat all individuals equally.

9.3. The group will ensure that it employs suitably qualified and experienced staff who will discharge their responsibilities in accordance with the high standards expected of staff employed by the group. All staff will be made aware of this constitution, the commissioning strategy and the relevant internal management and control systems which relate to their field of work.

9.4. The group will maintain and publish policies and procedures (as appropriate) on the recruitment and remuneration of staff to ensure it can recruit, retain and develop staff of an appropriate calibre. The group will also maintain and publish policies, approved by the Remuneration Committee, on all aspects of human resources management, including grievance and disciplinary matters.

9.5. The group will ensure that its rules for recruitment and management of staff provide for the appointment and advancement on merit on the basis of equal opportunity for all applicants and staff.

9.6. The group will ensure that employees' behaviour reflects the values, aims and principles set out above.

9.7. The group will ensure that it complies with all aspects of employment law.

9.8. The group will ensure that its employees have access to such expert advice and training opportunities as they may require in order to exercise their responsibilities effectively.

9.9. The group will adopt a Code of Conduct for staff and will maintain and promote effective 'whistleblowing' procedures to ensure that concerned employees have means through which their concerns can be voiced. The group recognises and confirms that nothing in or referred to in this constitution (including in relation to the issue of any group press release, other public statement or disclosure) will prevent or inhibit the making of any protected disclosure (as defined in the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998) by any member of the group, any member of its governing body, any member of any of its committees or sub-committees or the committees or sub-committees of its governing body, or any employee of the group or of any of its members, nor will it affect the rights of any worker (as defined in that Act) under that Act.

9.10. Copies of this Code of Conduct, together with the other policies and procedures outlined in this chapter, will be available on the group’s website at www.wolverhamptonccg.nhs.uk, available for inspection at the group’s offices, and either by post or email, on request.

10. TRANSPARENCY, WAYS OF WORKING AND STANDING ORDERS

10.1. General

10.1.1. The group will publish annually a commissioning plan and an annual report, presenting the group's annual report to a public meeting. This will be available on the group's website at www.wolverhamptonccg.nhs.uk, available for inspection at the group's offices, and either by post or email, on request

10.1.2. Key communications issued by the group, including the notices of procurements, public consultations, governing body meeting dates, times, venues, and certain papers will be published on the group's website at www.wolverhamptonccg.nhs.uk.

10.1.3. The group may use other means of communication, including circulating information by post, or making information available in venues or services accessible to the public.

10.2. Standing Orders etc

10.2.1. This constitution is also informed by a number of documents which provide further details on how the group will operate and which are deemed to be part of this constitution. They are the group's:

a) *Standing Orders* (Appendix E)***,*** which set out the arrangements for meetings and the appointment processes to elect the group's representatives and appoint to the group's committees, governing body and its committees;

b) *Scheme of reservation and delegation* (Appendix F)*,* which sets out those decisions that are reserved for the membership as a whole and those decisions that are the responsibilities of the group's governing body, the governing body's committees and sub-committees, the group's committees and sub-committees, individual members and employees;

c) *Prime financial policies* (Appendix G), which set out the arrangements for managing the group's financial affairs.

APPENDIX A

DEFINITIONS OF KEY DESCRIPTIONS USED IN THIS CONSTITUTION

2006 Act	National Health Service Act 2006
2012 Act	Health and Social Care Act 2012 (this Act amends the 2006 Act)
Accountable Officer	an individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by the NHS Commissioning Board, with responsibility for ensuring the group complies with its obligations under: • sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act), • sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act), • paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and • any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Board for that purpose; and exercises its functions in a way which provides good value for money.
Area	the geographical area that the group has responsibility for, as defined in Chapter 2 of this constitution
Chair of the governing body	the individual appointed by the group to act as chair of the governing body
Chief Finance Officer	the qualified accountant employed by the group with responsibility for financial strategy, financial management and financial governance
Clinical Commissioning Group	a body corporate established by the NHS Commissioning Board in accordance with Chapter A2 of Part 2 of the 2006 Act (as inserted by section 10 of the 2012 Act)
Committee	a committee or sub-committee created and appointed by: • the membership of the group • a committee/sub-committee created/appointed by a committee created/appointed by the membership of the group • the governing body or one of its committees
Financial year	this usually runs from 1 April to 31 March, but under paragraph 17 of Schedule 1A of the 2006 Act (inserted by Schedule 2 of the 2012 Act), it can for the purposes of audit and accounts run from when a clinical commissioning group is established until the following 31 March
Group	NHS Wolverhampton Clinical Commissioning Group, whose constitution this is
Governing body	the body appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that a clinical commissioning group has made appropriate arrangements for ensuring that it complies with: • its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and • such generally accepted principles of good governance as are relevant to it.
Governing body member	any member elected or appointed to the governing body of the group

Healthcare professional	A member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002
Lay member	a lay member of the governing body, appointed by the group. A lay member is an individual who is not a member of the group or a healthcare professional or as otherwise defined in regulations
Locality Board Chairs	the individuals to be appointed by the locality boards to act as chairs of their respective localities
Member	a provider of primary medical services to a registered patient list, who is a member of this group (see tables in Chapter 3 and Appendix B)
Practice representatives	an individual appointed by a practice (who is a member of the group) to act on its behalf in the dealings between it and the group, under regulations made under section 89 or 94 of the 2006 Act (as amended by section 28 of the 2012 Act) or directions under section 98A of the 2006 Act (as inserted by section 49 of the 2012 Act)
Registers of interests	registers a group is required to maintain and make publicly available under section 14O of the 2006 Act of the interests of: • the members of the group; • the members of its governing body; • the members of its committees or sub-committees and committees or sub-committees of its governing body; and • its employees.
Regulations	Any regulations issued by the Secretary of State under the 2006 Act,2012 Act or any other relevant legislation that determine the duties, powers or conduct of a clinical commissioning group

APPENDIX B - LIST OF MEMBER PRACTICES

Practice Name	Address
Dr S Agrawal Tudor Medical Practice	1 Tudor Road , Heath Town Wolverhampton, WV10 0LT
Dr S Asghar Caerleon Surgery	Dover Street Bilston Wolverhampton WV14 6AL
Dr D Bagary Low Hill Medical Centre	191 First Avenue, Low Hill Wolverhampton, WV10 9SX
Dr R Bilas & A Thomas	75 Griffiths Drive, Ashmore Park, Wednesfield, WV11 2JN
Dr D Bush Penn Surgery	2a Coalway Road, Penn Wolverhampton, WV3 7LR
Dr U Chelliah Showell Park	Fifth Avenue Wolverhampton WV10 9ST
Dr S Cowen & Partners The Surgery	119 Coalway Road, Penn Wolverhampton, WV3 7NA
Dr D DeRosa & Dr A Williams Warstones Health Centre	Pinfold Grove, Warstones Wolverhampton, WV4 4PS
Dr G Dhillon Ashfield Surgery	39 Ashfield Road, Fordhouses Wolverhampton, WV10 6QX
Dr J Fowler	470 Stafford Road Wolverhampton, WV10 6AR
Dr George & Partner Ashmore Park Health Centre	Griffiths Drive, Ashmore Park Wednesfield, WV11 2LH
Dr Hibbs & Partners Ettingshall Medical Centre	Herbert Street, Ettingshall Wolverhampton WV14 0NF
Dr Hibbs & Partners Parkfields Medical Practice	255 Parkfield Road, Parkfields Wolverhampton WV4 6EG
Intrahealth (Dr V Rai) Bilston Urban Village Medical Centre	Bankfield Road, Bilston Wolverhampton WV14 0EE
Intrahealth Pennfields Medical Centre	Upper Zoar Street, Pennfields Wolverhampton WV3 0JH
Dr Jackson & Partners Tettenhall Medical Practice	Lower Street Tettenhall Wolverhampton WV6 9LL
Dr J Kainth All Saints Surgery	17 Cartwright Street, All Saints Wolverhampton WV2 3BT
Dr M Kainth Primrose Lane Health Centre	Primrose Lane, Low Hill Wolverhampton WV10 8RN
Dr S Kanchan	1 Shale Street, Bilston Wolverhampton WV14 0HF
Dr M Kehler Keats Grove Surgery	7 Keats Grove, The Scotlands Wolverhampton WV10 8LY
Dr A Khan Duncan Street Primary Care Centre	Duncan Street, Blakenhall Wolverhampton WV2 3AN
Dr R Kharwadkar	68 Marsh Lane, Fordhouses Wolverhampton, WV10 6RU
Dr K Krishan Mayfields Medical Centre	272 Willenhall Road Wolverhampton, WV1 2GZ
Dr C Lal Bradley Medical Centre	83-84 Hall Green Street, Bradley Wolverhampton, WV14 8TH
Dr H Leung & Partner Lea Road Medical Practice	35 Lea Road, Pennfields Wolverhampton, WV3 0LS

Practice Name	Address
Dr Libberton	60 Cannock Road Wednesfield WV10 8PJ
Dr G Mahay Poplars Medical Practice	Third Avenue, Low Hill Wolverhampton WV10 9PG
Dr S Mittal Probert Road Surgery	Probert Road, Oxley Wolverhampton, WV10 6UF
Dr J Morgans & Partners	81 Prestwood Road West Wednesfield, WV11 1HT
Dr N Mudigonda Bilston Health Centre	Prouds Lane, Bilston Wolverhampton, WV14 6PW
Drs K Ahmed, V Pahwa & V Rai Bilston Health Centre	130a Park Street South, Goldthorn Hill Wolverhampton WV2 3JF
Dr J Parkes Alfred Squire Road Health Centre	Alfred Squire Road Wednesfield W11 1XU
Dr U Passi & Handa Leicester Street Medical Centre	Leicester Street, Whitmore Reans, Wolverhampton WV6 0PS
Dr G Pickavance & Partners The Newbridge Surgery	255 Tettenhall Road Wolverhampton WV6 0DE
Dr S Ravindran & Majid East Park Medical Centre	Jonesfield Crescent, East Park Wolverhampton WV1 2LW
Dr H Richardson & Partners Thornley Street Surgery	40 Thornley Street Wolverhampton WV1 1JP
Dr A Saini & Partner	62-64 Church Street, Bilston Wolverhampton WV14 0AX
Dr A Sharma & Partner Bilston Health Centre	Prouds Lane, Bilston Wolverhampton, WV14 6PW
Dr S Suryani The Surgery	Hill Street, Bradley, Wolverhampton WV148SB
Dr S Taylor & Cam	80 Tettenhall Road, Tettenhall Wolverhampton, WV1 4TF
Dr P Venkataramanan & Partner Grove Medical Centre	175 Steelhouse Lane Wolverhampton WV2 2AU
Dr Vij & Partners Whitmore Reans Health Centre	Lowe Street, Whitmore Reans Wolverhampton WV6 0QL
Dr Wagstaff & Partners Castlecorft Medical Practice,	Castlecroft Avenue Wolverhampton WV3 8JN
Dr White & Partners Penn Manor Medical Centre	Manor Road, Penn Wolverhampton WV4 5PY
Dr Whitehouse	199 Tettenhall Road Wolverhampton WV6 0DD

APPENDIX C - NOLAN PRINCIPLES

1. The 'Nolan Principles' set out the ways in which holders of public office should behave in discharging their duties. The seven principles are:

   a) **Selflessness** – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

   b) **Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

   c) **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

   d) **Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

   e) **Openness** – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

   f) **Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

   g) **Leadership** – Holders of public office should promote and support these principles by leadership and example.

Source: *The First Report of the Committee on Standards in Public Life* (1995)[60]

[60] Available at http://www.public-standards.gov.uk/

APPENDIX D – NHS CONSTITUTION

The NHS Constitution sets out seven key principles that guide the NHS in all it does:

1. **the NHS provides a comprehensive service, available to all** - irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population

2. **access to NHS services is based on clinical need, not an individual's ability to pay** - NHS services are free of charge, except in limited circumstances sanctioned by Parliament.

3. **the NHS aspires to the highest standards of excellence and professionalism** - in the provision of high-quality care that is safe, effective and focused on patient experience; in the planning and delivery of the clinical and other services it provides; in the people it employs and the education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population.

4. **NHS services must reflect the needs and preferences of patients, their families and their carers** - patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment.

5. **the NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population** - the NHS is an integrated system of organisations and services bound together by the principles and values now reflected in the Constitution. The NHS is committed to working jointly with local authorities and a wide range of other private, public and third sector organisations at national and local level to provide and deliver improvements in health and well-being

6. **the NHS is committed to providing best value for taxpayers' money and the most cost-effective, fair and sustainable use of finite resources** - public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves

7. **the NHS is accountable to the public, communities and patients that it serves** - the NHS is a national service funded through national taxation, and it is the Government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. The Government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose

Source: *The NHS Constitution: The NHS belongs to us all* (March 2012)[61]

[61] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132961

Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
11 OCTOBER 2016

Title of Report:	**Black Country Sustainability and Transformation Plan**
Report of:	Director of Strategy and Solutions
Contact:	Steven Marshall
(add board/ committee) Action Required:	☒ **Decision** ☒ **Assurance**
Purpose of Report:	To seek agreement from the Governing Body for the Black Country Sustainability and Transformation Plan (STP) to be submitted on 21 October as a draft work in progress which will be subject to full consultation and engagement. The report also 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 and implementation of the Black Country STP
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	Agreeing and contributing to the STP is one of the 9 'Must dos' for the CCG as outlined in the Operating Plan
Relevance to Board Assurance Framework (BAF):	Outline which Domain(s) the report is relevant to and why – See Notes for further information
• **Domain 3:** Financial Management	One of the key aims of The STP is to support work to return the system to financial balance over the course of the STP.
• **Domain 4:** Planning (Long Term and Short Term)	The STP is a key element of the CCG's Strategic and Operational planning framework

1. BACKGROUND AND CURRENT SITUATION

1.1. Sustainability and Transformation Plans (STPs) are local plans to improve health and care plans, they will support the delivery of a national plan called the Five Year Forward View (5YFV). Published in 2014, it set out a vision of a better NHS, and the steps to take to achieve the vision by 2020/21.

1.2. To succeed, STPs will need to be developed with, and based upon, the needs of local patients and communities and engage clinicians and other care professionals, staff and wider partners such as local government.

2. BLACK COUNTRY STP

2.1. There are 18 partners to the Black Country STP who have been engaged over recent months in establishing a broad plan for sustainability and transformation of local health and care, which can be delivered by 2020/21.

2.2. The key areas upon which the partners have focused have been care and quality; health and wellbeing; and finance efficiency. Initial proposals have centred on:-

- How demand for services might be more effectively managed through integrated working between primary care, secondary care, mental health, community services and social care.
- How to reduce variation in secondary care through standardised pathways and more efficient use of staff and facilities.
- How to improve the commissioning and provision of mental health services and to reduce the need for patients to be placed out of area
- How to improve commissioning and provision of maternity and infant health services

All partners are working towards plans which deliver the above and also lead to a balanced financial position for the STP footprint.

2.3. There is much work to be done on the detail of the above proposals which will in turn highlight a range of implications for patients, the public, staff and the individual partner organisations. In developing the required detail it is essential that the appropriate consultation and engagement is undertaken to ensure that all organisations have a mandate to formally agree a final plan which can be submitted to the national sponsoring bodies. Subject to national sign off the plans would then move to implantation over the next 4 to five years.

3. NEXT STEPS

3.1. The current iteration of the Black Country STP will be submitted to NHS England on 21 October and it will be considered by the national sponsoring bodies. It is expected

that the plan will either be given approval, in which case it is likely to move to implementation from around January 2017, or further work will be mandated to achieve the required level of detail to enable final approval.

4. CLINICAL VIEW

4.1. Clinical views will be sought through the engagement work detailed below.

5. PATIENT AND PUBLIC VIEW

5.1. The 18 partner organisations in the Black Country STP have all been engaged through regular meetings which have been established to progress the early thinking. These meetings have also involved representation from Healthwatch across the Black Country and more recently arrangements have been put in place for representation from the Voluntary and Community Sector and also Local Medical Committees.

5.2. It is intended that following submission of the draft Black Country STP in October that detailed plans for consultation and engagement will be published. The process will involve the full range of stakeholders including:-

- Service users, carers, families
- Children and young people
- Staff
- Clinical Leaders
- Local Council, MPs and councillors
- NHS England
- Press and media

5.3. A range of approaches will be employed including forums, written material, websites and social media. The use of existing channels and governance and assurance processes will be maximised to ensure formal and informal opportunities to gain opinion and influence are realised. This will explicitly include Health and Well Being Boards and Overview and Scrutiny Committees.

5.4. There will be some events that take place on a Black Country footprint but the vast majority of engagement and consultation will be undertaken through local organisations on a borough by borough basis.

6. RISKS AND IMPLICATIONS

Key Risks

6.1. There are no specific risks associated with the report. Risks identified in the preparation of the STP are being managed by appropriate workstreams.

Financial and Resource Implications

6.2. There are no specific financial implications associated with this report. The financial implications of the STP for the CCG will be articulated in detail through the on-going planning process for 2017/18 and beyond.

Quality and Safety Implications

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

Equality Implications

6.4. The engagement activity detailed above will seek views from across the community, including those with protected characteristics. Further analysis will take place as details of proposals relating to the STP emerege.

Medicines Management Implications

6.5. There are no specific medicines management implications arising from this report.

Legal and Policy Implications

6.6. There are no specific legal or policy implications arising from this report.

7. RECOMMENDATIONS

7.1. **That the Governing Body agree to the submission of the Black Country STP on 21 October noting that it is a draft work in progress which will be subject to full consultation and engagement.**

Name	**Steven Marshall**
Job Title	**Director of Strategy and Transformation**
Date:	**October 2016**

RELEVANT BACKGROUND PAPERS

NHS Planning Guidance 2016/17 and 2017/18

REPORT SIGN-OFF CHECKLIST

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

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

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body Meeting – 11th October 2016

Agenda item 10

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

2. MAIN BODY OF REPORT

2.1 Contracting & Procurement Update

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.

E-discharge

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.

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

2.2 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.

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 the annual

Action – The Committee request that Governing Body support the action taken.

2.3 Atrial Fibrillation

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.

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

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

2.4 Nuffield Health Ltd Business Case for a Spinal Service

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.

The Committee approved the Business Case.

3. RECOMMENDATIONS

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

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

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body - Tuesday 11TH October 2016

Agenda item 11

Title of Report:	**Executive Summary from the Quality & Safety Committee** **Assurance Report for Section 11 Audit Safeguarding Children**
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. Report on Section 11 provides assurance to the Governing Body that the CCG is meeting its Statutory Responsibility for Safeguarding Children.
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

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

Key Issue	Level	Comments	Detail on page/RAG
SBAR issues escalated	2	• Delayed diagnoses • Delayed treatment • NEs • Sub-optimal care (transfer of patient)	6 (Red)
Confidential Leaks	1	Close monitoring	6 (Amber)
Pressure Injury Grade 3	1	Close monitoring	8 (Amber)
Health Acquired Infections- CDiff	2	Increasing incidence of Cdiff, trust failed its 2015/16 target	10 (Red)
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.	(Red)
Workforce- RWT Risk Register	2	RWT Nursing and consultant recruitment issues are impacting on Quality and Patient Safety and A&E performance.	14 (Red)
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 September.	19 (Red)
LAC	2	Wolverhampton remains an outlier for number of LAC. There is a city wide strategy in place with improvements seen.	19 (Orange)
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 (Red)
CQC Inspection Reports (BCPFT & RWT)	2	Rating 'requires improvement' for RWT. Action Plans in place. RWT is awaiting the final report.	10/16 (Orange)
CQC General Practice	1	2 practices are being supported for 'requires improvement'	11 (Orange)
Mortality	1	Within expected limits, some data cleansing and audits being conducted.	13 (Green)

Falls	1	Improvements seen in number of falls causing serious harm. CCG will maintain focus	7

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 13th September 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.

In addition, there is an assurance report on the statutory completion of the Section 11 Audit for Children's Safeguarding; this is included in the committee reports for information.

1. 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:

- Maternal and 32 weeks gestation fetal death. An SI was reported by RWT that following a forced entry into a property, a lady believed to be the mother and a 32 week gestation infant were found deceased. A full investigation has commenced and the initial 48 hr report does not suggest anything suspicious.
- RWT reported a Never Event where the consultant doctor injected the wrong heal during an invasive surgical procedure. No harm was reported to the patient and the right heal was treated successfully.

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

The current CCGs internal assurance framework sets out the business critical factors for the CCG to deliver its essential functions, and in turn allows the CCG to identify any risks that may impact on its ability to deliver the national requirements. It is based upon the national Assurance Framework and associated key lines of enquiry, combined with local priorities 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.
A Governing Body development session was undertaken on 27th September with PricewaterhouseCoopers. Several actions have been agreed as a result of this session and the Governing Body members present have agreed the following to take place in the coming months:

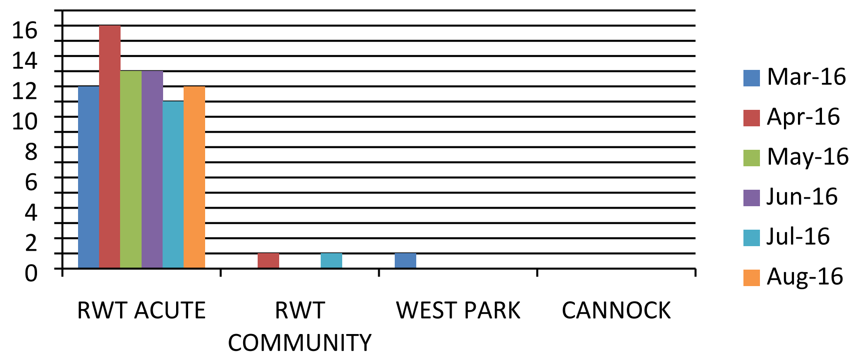
- CCG Strategic Objectives to be reconfirmed in the context of the wider Risk Register and BAF work.
- Several different examples of BAFs being used across the health economy were shared and discussed. Quality and Risk Team are working on a drafting a couple of different models which will be shared at a future GB meeting.
- The Risk Register is being 'cleansed'.

The next Governing Body update for BAF will be in November 2016.

4.0 THE ROYAL WOLVERHAMPTON NHS TRUST

4.1 Serious Incidents (SIs)

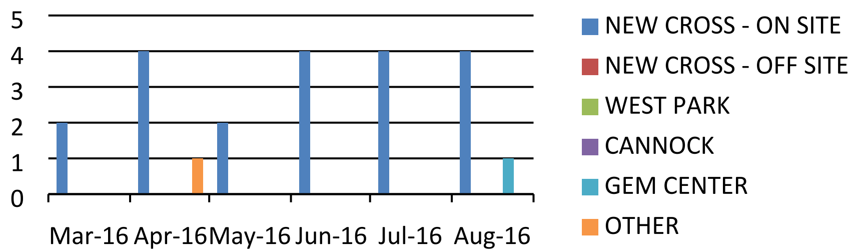
12 new Serious Incidents were reported by RWT in August 2016.



The Trust has initiated an external review of SIs reported from key areas as A&E and emergency admissions areas. This is currently underway and the findings will be shared at a forth coming CQRM.

4.2 Confidential Breaches

This remains an area of concern; 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 has not shown the expected sustained improvement at the acute site and the Trust has been requested to review this and report findings to the November CQRM.



4.3 Never Events

The Trust has reported a Never Event in September 2016. This was an incident related to an injection being administered into the wrong heal. No harm was reported, however, in line with national reporting requirements the Trust are undertaking a full RCA. The root cause will review the use of the WHO Safer Surgical Check List and learning will be shared across the Trust.

Total NEs for 15/16 was 3 and YTD 16/17 is 2.

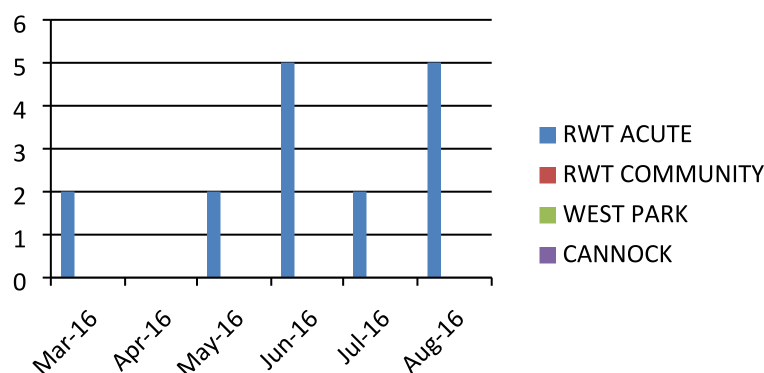
4.4 Slips Trips and Falls

There were 5 slip/trip/falls incidents meeting the SI criteria reported by RWT in August 2016, all occurred at New Cross Hospital. Apart from an improvement in July, August has seen a decline in performance. There have been zero reported falls at West Park, community or Cannock Chase Hospital. This information has been verified since the last report.

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

Performance is being monitored closely and triangulated with other ward dashboard themes i.e. low staffing, other safety incidents, patient and staff experience surveys and the CCG performance team at CQRMs. A further update will be provided in November.



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 lead to the variation in practice across the health economy and key areas to address have been identified as:

- 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.

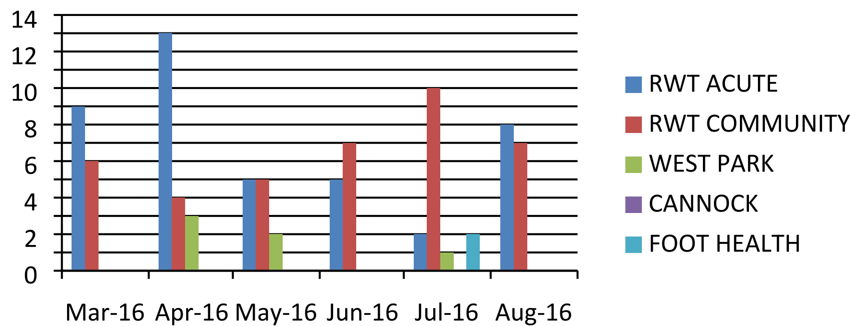
This work is currently underway and being driven by the group

In August, 15 Grade 3 Pressure Injury incidents were reported by RWT; 8 at RWT site, 7 in the Community.

There is an improvement in the monthly incidents reported over the last 6 months; especially since April. All incidents are discussed at the bi weekly scrutiny meetings which the CCG attend and are graded as avoidable or unavoidable

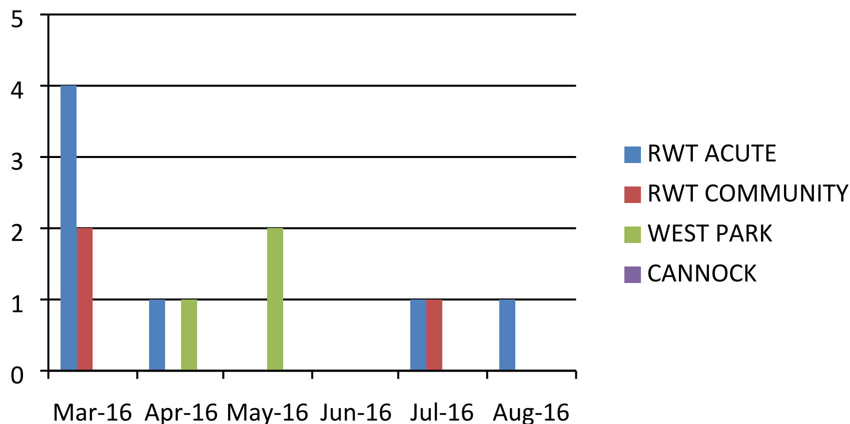
following a comprehensive RCA. These meetings are chaired by the Trusts' Chief Nurse and the head nurses from each area affected have to attend with their RCA findings and action plans. Across the region, this is held up as a best practice and demonstrates true ownership of the issue at director level.

Future reporting of these will include the avoidable and unavoidable data. (This is currently being planned into future report templates).



4.6 Pressure Injury Grade 4

One Grade 4 Pressure Injury was reported by RWT in August. This is encouraging and early indication is that the Trust prevention of pressure injury deterioration initiatives in place are having a positive impact.



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

Staph aureus Bacteraemia – The Trust had reached its internal target of 2, having had 3 cases in month.

MRSA Hospital acquired – zero reported for August 2016.

MRSA Acquisitions – 2 reported for August 2016

Clostridium *difficile* – The Trust had hit its internal target of 9. In August there were a total of 16 Toxin positives; 8 were attributable to RWT and 8 were to CCG, however, early indication for September is that there were 2 toxin positives. September data will be validated on 15th October 2016. None were reoccurrences (i.e. no association between previous admissions in the previous six months and there were no clusters. More sustainable improvement is being targeted via junior doctors during the August induction.

The quarterly CCG CDI rate was the lowest rate recorded for a number of years, and the monthly CDI rate per hundred thousand bed days also showed some good improvement against the regional average. The Trust remains an outlier in relation to attributable CDI rates.

Blood Culture Contamination rates – Figures for the month showed that all 4 of the contaminants were within Paediatrics and this is being addressed through junior doctor education.

Device related hospital acquired bacteraemia – 5 in August for acute site and 7 in community; 6 urinary catheters and 1 line inserted which was managed by another acute provider.

The hand hygiene figures were the best ever achieving 96% compliance. Medical staffs remain slightly under compliance but there is some dedicated work being undertaken with all but especially junior doctors.

Antimicrobial Prescriber Training fell short of the 95% target at 92.1%. It was noted that over the last quarter figures for Division 1 had increased, but Division 2 figures had remained almost static for the same period. This is being addressed by the matrons and assurance is sought at the monthly CQRM and RWTs IPC meeting.

Risk Register – Clostridium *difficile* remains as amber on the Trust Risk Register and the Trust is off monthly trajectory with potential to breach the annual total. An extensive action plan is in place.

In September, the Trust launched an Anti-Microbial Stewardship Programme which the CCG has supported through some funding. The Trust is also participating in a national point prevalence survey (PPS) audit. The PPS audit will be carried out at acute Trusts in the UK and Europe. The information collated will inform and improve the understanding of local, national and 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.

4.8 West Midlands Quality Review Service

There are currently no active action plans from reviews. All are complete and closed. There is an ongoing programme of reviews planned for 16/17 and there is a robust system in place for the CCG to be involved from planning to closure.

4.9 Performance

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

4.10 **NHS Safety Thermometer**

RWT's harm free care rate to July was 92.99%. Specific areas of harm are related to pressure injury, falls and new VTE.

Assurance: data from several sources has been triangulated. The Trust is reviewing the ward dashboards to identify key themes. This remains under for close scrutiny at present until a step change is seen and sustained.

4.11 Regulator concerns

4.11.1 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. Exception will be reported to the Local Children's Safeguarding Board. With the second meeting on October 7th, no issues have been raised.

4.11.2 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'.

4.11.3 CQC BCPFT

BCPFT CQC Risk Summit was held in May. A substantial action plan is in place and this is being monitored at CQRM and Contract Meetings. The Governing Body will be kept appraised of any exceptions.

4.11.4 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.

4.11.5 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 have arranged to accompany the CCG Quality Team at 3 visits in September and October and more will be planned in the New Year. This is now in place, Healthwatch have attended a joint visit to the A&E and UCC on 26th September 2016.

4.12 Primary Care Joint Commissioning Committee (PCJCC)

The Primary Care Liaison Group has now morphed into The Primary Care Operational Management Group. Discussions from this meeting are shared with the PCJCC.

As part of the improving quality in primary care initiatives, the CCG has considered what other support can be given to practices and how this would be delivered and monitored. A Primary Care Quality Assurance Coordinator role has been created and recruited into. The incumbent starts employment on 1st September and will work closely with the new Head of Primary Care in assuring systems and processes to improve quality of care in primary care to successfully deliver the CCG Primary Care Strategy and is expected to commence employment in September.

Assurance – monthly overview reports from the PCOMG are discussed at the Primary Care Joint Commissioning Committee (PCJCC) to monitor areas of escalated concern. The Primary Care Strategy Committee is now also fully operational.

4.13 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 benchmark (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

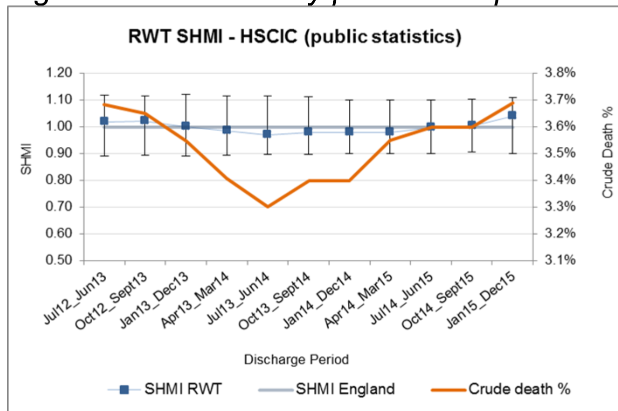
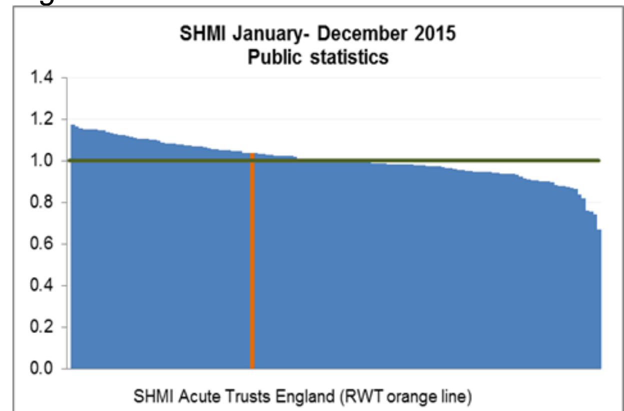


Fig. 2 RWT's SHMI for the latest 12 months



(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 August 2016 and the analysis is being reviewed and shared at the next Trust MORAG meeting.

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 is 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 that met on 22 March 2016. 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.

4.14 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)**
- 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)**

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

The CCG Primary Care Workforce Analysis has now been concluded and a full suite of documents compiled including a draft strategy (undergoing some final refinement before ratification), workforce data for general practice staff and an implementation plan.

5.0 BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST Level of Concern as of 31st August 2016.

Black Country Partnership	
Month	**Concern Level and Actions**
August 2016	Level 2 – Recent CQC inspection rated the Trust as Requiring Improvement. BCPFT has an action plan in place and has now shared this with WCCG. Concern level to be reviewed following re-inspection by CQC possibly in six months' time. Action plan continues to be monitored at CQRM.

a) PREVENT Training

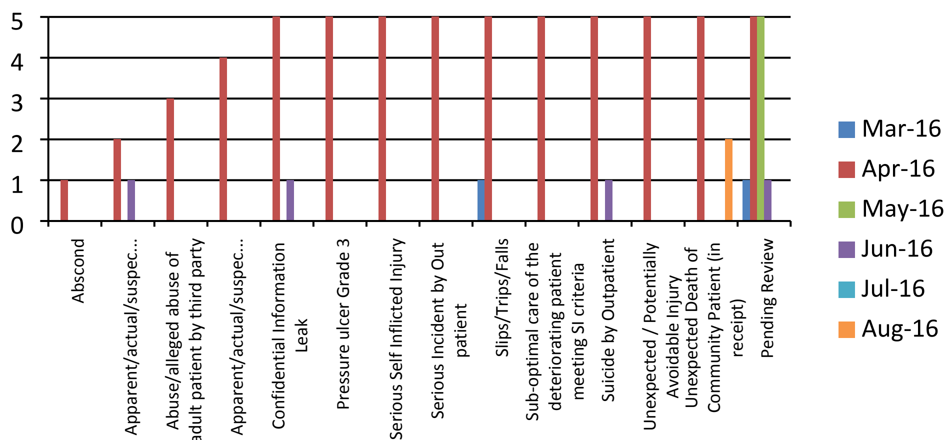
Remedial action plan agreed in June. This will be monitored via CQRM and Contract Review Meetings.

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

2 SIs of unexpected death of community patients were reported, both have a stop clock applied due to the nature of the investigation i.e. police and coroner.



5.2 Never Events – zero reported

5.3 Falls – zero falls were reported.

5.4 Numbers of Overdue SI's – zero

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

5.6 NHS Safety Thermometer

BCPFT's harm free care rate for July 2016 was 97.6%. 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 August 2016 was CAMHS. Key areas to note were:

RED Indicators - Month 4 (July 2016) BCPFT dashboard shows reporting on national and local quality requirements

Friends and Family Test – the Trust is receiving positive FFT responses. Suggestions from respondents include shorter waiting times and weekend/evening clinics.

CQC Safeguarding Inspection – the CQC Safeguarding inspection in July in Wolverhampton raised a concern regarding the perinatal pathway. BCPFT was given detailed feedback on the day of the visit and WCCG will share the formal report once it is received. Feedback meeting will also be held.

PREVENT Contract Performance Notice – currently being monitored via WCCG Contracting Team. Training figures are currently 57% for Levels 3 and 4 WRAP training, with a target of 85% by December 2016.

The CQUIN for 15/16 – Quetiapine remains not achieved, action plan agreed and is being monitored via Contract Review Meetings.

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. 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

A SCR has been competed on a Wolverhampton resident family, due to the high likeliness of family identification, advice has been sought from the national panel on limited publication. The report will be published later this year.

7.2 Section 11 Audits are currently being undertaken across the health economy. Primary Care is also required to be engaged in these, we are hoping for good levels of responses and the Safeguarding teams are available for additional support. As a statutory responsibility the CCG Section 11 Audit will be shared with the Q&S Committee in September and then subsequently with the Governing Body (report is attached under Committee Reports Quality and Safety).

7.3 Looked After Children

The number of LAC continues to show a positive decrease, Wolverhampton CCG remain active partners within multi-agency arrangements and core corporate duties and responsibilities. The following table demonstrates the number of LAC for the month of August 2016

	Number	%age
Wolverhampton City Council	**270**	**42.3**
Dudley Metropolitan Borough Council	40	6.3
Sandwell Metropolitan Borough Council	32	5.0
Walsall Metropolitan Borough Council	46	7.2
South Staffordshire Council	33	5.2
All in Adjoining LAs	**151**	**23.6**
Anywhere Else - not in W'ton or in Adjoining LAs	**218**	**34.1**
TOTAL LAC	**639**	**100**

8.0 ADULT SAFEGUARDING

8.1 The Quality and Safety Committee received a detailed assurance report on adult safeguarding, comprising the following key points:-

- Wolverhampton Safeguarding Adults Board
- Mental Capacity Act /Deprivation of Liberty Safeguards (MCA/DOLs)
- Adult MASH
- Domestic Homicide Review Standing Panel
- Safeguarding Adult Review Committee
- NHS England Safeguarding Projects

The report also detailed assurances regarding quality indicators in provider contracts and how improvements had been made in 2016/17 contracts and the introduction of an Assurance Framework for Services commissioned by the CCG to provide consistency in reporting, eliminate duplication and identifies timings for the provision of information. The report was fully accepted by the committee.

The CCG has recruited to the post of substantive, fulltime Designated Adult Safe Guarding Lead; the 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	PL
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.

Out of area homes which have Wolverhampton health or social care funded patients and that are of concern are monitored jointly as in area homes and in addition escalation communication is shared with NHSE and the appropriate CCG for awareness. I.e. Hunters Lodge Care Home, Staffordshire. Quality concerns have been raised and shared with Stafford commissioners and with NHSE Quality team.
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 end of October.

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.

Further plan:

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.

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 August, information from Quality Review Meetings held during the month of July 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

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

14.2 Quality and Safety Implications

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

14.3 Equality Implications

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

14.4 Medicines Optimisation Implications

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

14.5 Legal and Policy Implications

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

15.0 Recommendations

For **Assurance**

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

Name: Manjeet Garcha

Job Title: **Director of Nursing and Quality**
Date: **4th 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**	**4.10/16**
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**	**Aug 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**	**04/10/16**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
11 October 2016

Agenda item 12

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 27 September 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	£350.237m	£350.237m	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	325	550	225	A
Maximum closing cash balance %	1.25%	2.12%	0.80%	A
BPPC NHS by No. Invoices (cum)	95%	98%	-3%	G
BPPC non NHS by No. Invoices (cum)	95%	94%	1%	A
QIPP	£3.92m	£3.65m	£0.04m	A
Programme Cost £'000*	137,896	138,661	765	G
Reserves £'000*	741	0	(741)	G
Running Cost £'000*	2,314	2,234	(80)	G

- The CCG continues to exceed the BPPC target of paying 95% of its invoices within 30 days (figures are cumulative April16-July16).

- Higher than anticipated cash balances were held at month end following an unexpected receipt from NHSE.

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

		YTD Performance M05			
	Annual Plan £'000	Plan £'000	Actual £'000	Variance £'000 o(u)	Var % o(u)
Acute Services	180,473	75,197	75,779	582	0.77%
Mental Health Services	34,455	14,356	14,276	(80)	(0.56%)
Community Services	37,731	15,721	15,601	(120)	(0.76%)
Continuing Care/FNC	12,259	5,108	5,562	454	8.89%
Prescribing & Quality	52,013	21,633	21,081	(551)	(2.55%)
Other Programme	16,425	5,881	6,362	480	8.17%
Total Programme	**333,356**	**137,896**	**138,661**	**765**	**0.55%**
Running Costs	5,555	2,314	2,234	(80)	(3.47%)
Reserves	5,154	741	0	(741)	(100.00%)
Total Mandate	**344,065**	**140,952**	**140,895**	**(57)**	(0.04%)
Target Surplus	6,172	2,723	0	(2,723)	(100.00%)
Total	**350,237**	**143,675**	**140,895**	**(2,780)**	(1.93%)

The table below details the forecast out turn by service line at Month 5

	Annual Plan £'000	Forecast Outurn at M05 Actual £'000	Forecast Outurn at M05 Variance £'000	Forecast Outurn at M05 Var %	Forecast Outurn at M04 Actual £'000	Forecast Outurn at M04 Variance o(u) £'000	Forecast Outurn at M04 Var %	In Month Movement £'000 o(u)
Acute Services	180,473	182,312	1,839	1.02%	182,027	1,514	0.84%	325
Mental Health Services	34,455	34,298	(157)	(0.45%)	34,267	(188)	(0.55%)	31
Community Services	37,731	37,518	(214)	(0.57%)	37,435	(296)	(0.78%)	82
Continuing Care/FNC	12,259	13,704	1,445	11.79%	13,362	1,103	9.00%	342
Prescribing & Quality	52,013	50,854	(1,159)	(2.23%)	50,932	(1,058)	(2.04%)	(101)
Other programme	16,425	16,449	24	0.15%	17,090	705	4.30%	(681)
Total Programme	**333,356**	**335,135**	**1,780**	**0.53%**	**335,111**	**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	**350,237**	**350,237**	**(0)**	(0.00%)	**350,213**	**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.
- Prescribing is continuing to underspend and month 5 reflects an improving position with the forecast underspend being increased from M4.The improvement in Other services is due to a reduction in unallocated QIPP and forecast under spends in other budgets.
- The variance in CHC costs is associated with increasing numbers in Terminal Phase as well as an increase in average length of stay in Terminal Phase,(an increase of 4 weeks from 6 to 10).

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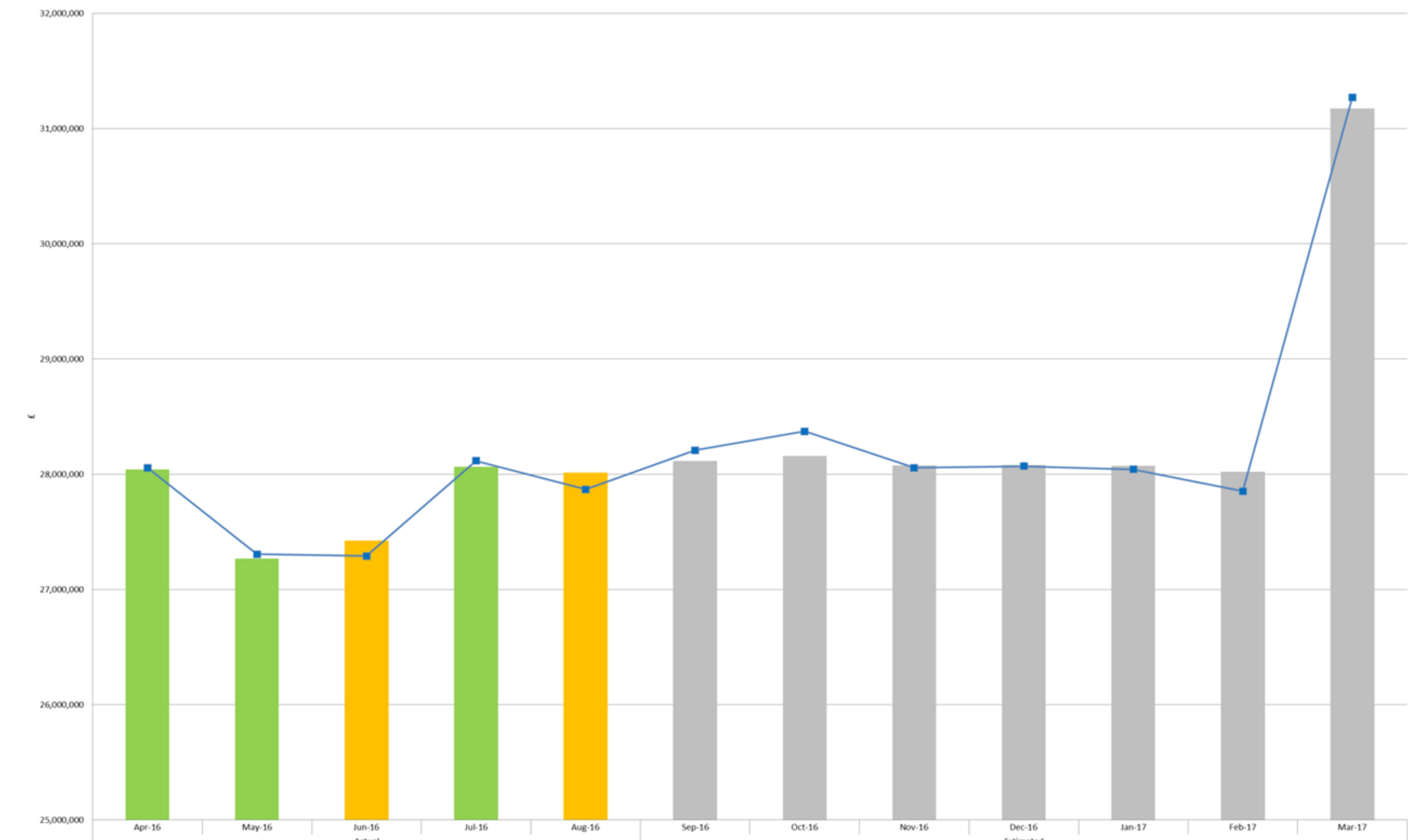
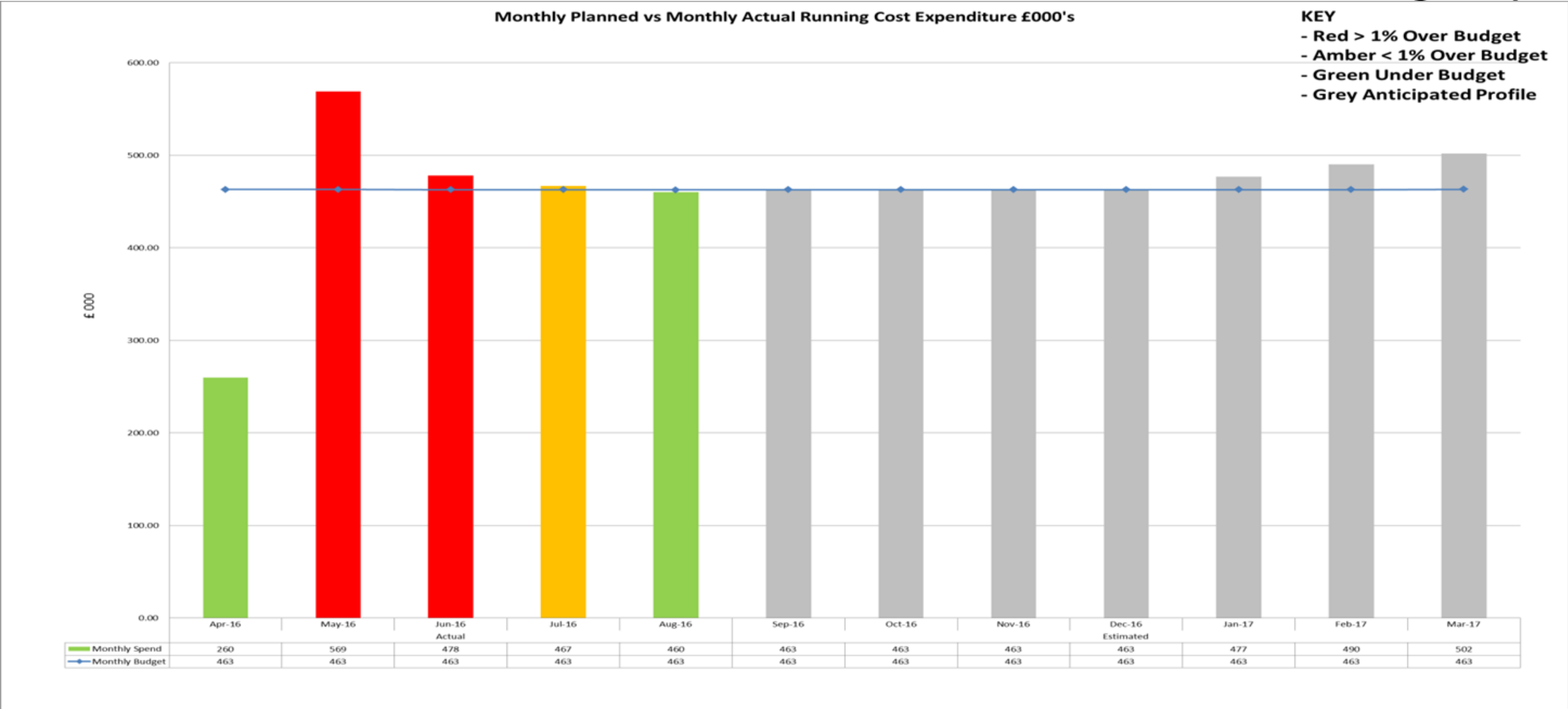


	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Monthly Spend	28,042,125	27,267,786	27,424,027	28,065,637	28,014,023	28,115,385	28,158,332	28,075,076	28,078,762	28,071,385	28,021,853	31,175,609
Monthly Budget	28,056,449	27,305,820	27,290,265	28,116,838	27,868,085	28,209,081	28,372,083	28,056,088	28,070,077	28,042,081	27,854,083	31,269,050



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Monthly Spend	260	569	478	467	460	463	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 deterioration in the QIPP Programme performance as at Month 5. The deterioration in the forecast outturn is due to the non-achievement of the BCF stretch target (£786k) offset by additional savings against other schemes including £400k relating to prescribing.

	YTD Plan £'m	YTD Actual £'m	YTD Var o(u) £m	An. Plan £'m	FOT £'m	Var o(u) £m
Transactional	0.94	1.22	0.28	2.21	3.27	1.06
Transformational	2.52	2.43	-0.09	6.93	6.57	-0.36
Unallocated	0.47	0.00	-0.47	2.12	0.00	-2.12
Total	**3.93**	**3.65**	**-0.28**	**11.26**	**9.84**	**-1.42**

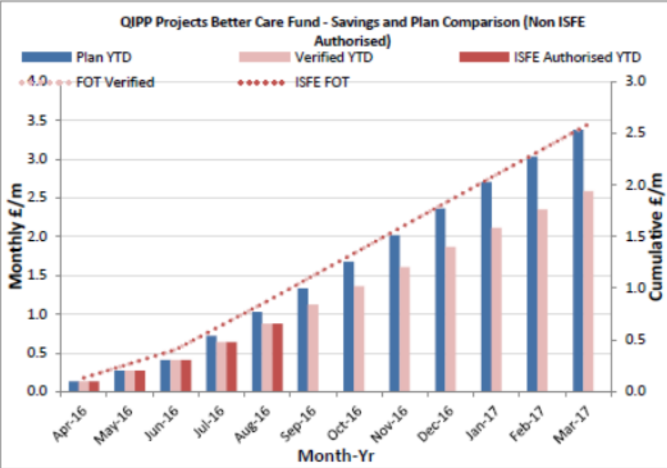
NHS Wolverhampton Clinical Commissioning Group

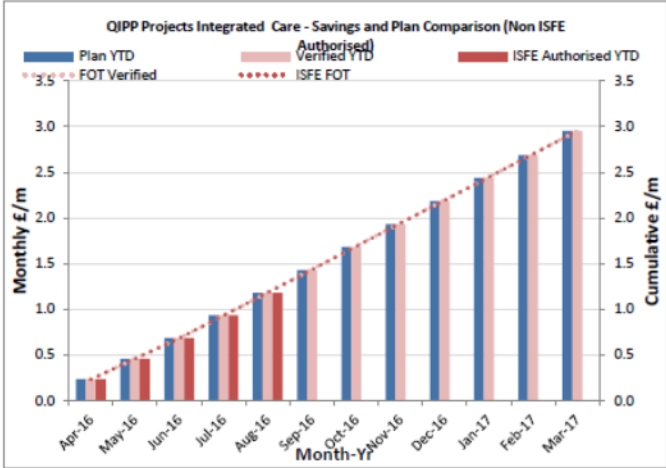
QIPP Programme Delivery Board - Validated Figures for Non ISFE

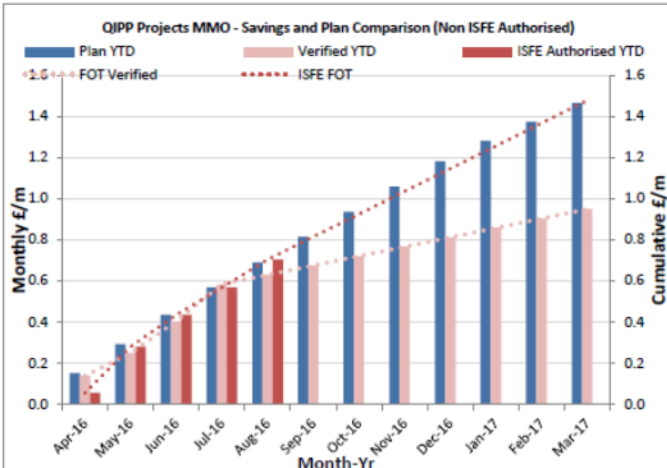
Reporting Period : Aug-16

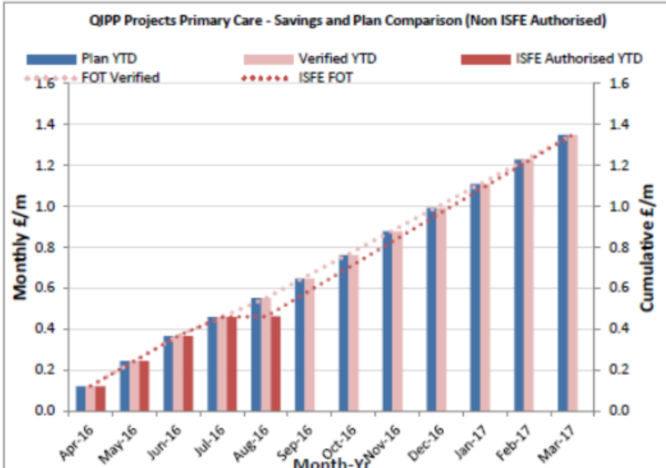
Financial Savings Projects within QIPP Programme Delivery Board and Annual Plan

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

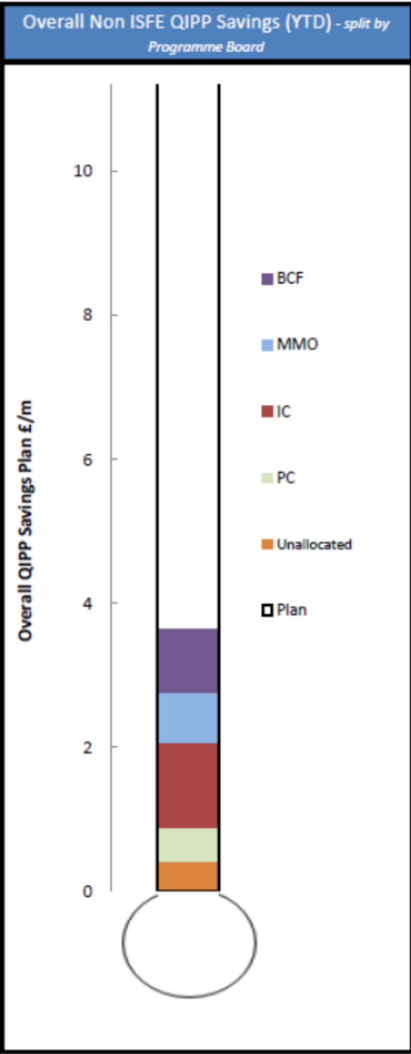








Overall Non ISFE QIPP Savings (YTD) - *split by Programme Board*



Note : Cumulative figures are based on a secondary axis

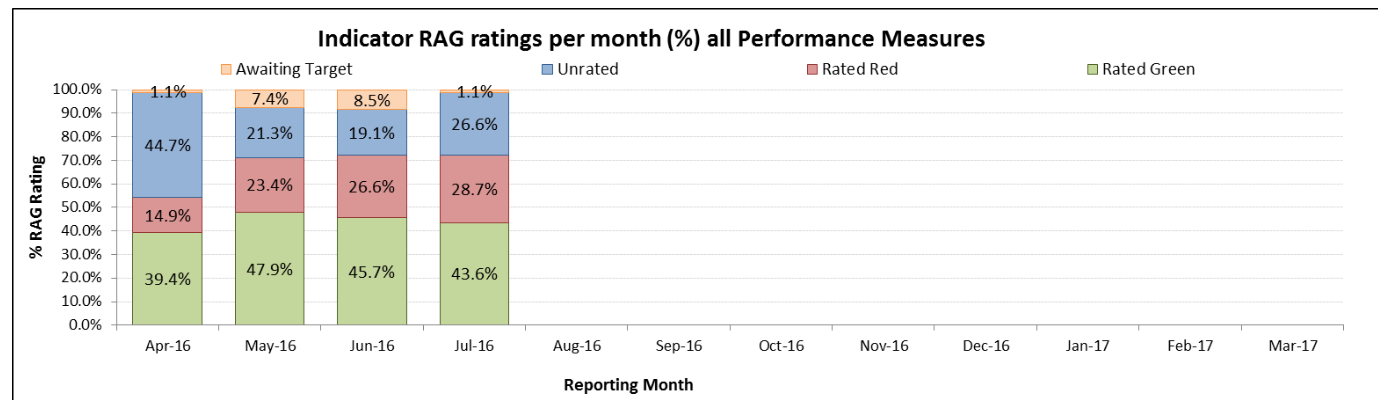
Note : Updates provided by Project Leads as verified figures on Project Highlight sheets may exclude data due to lags in data availability.

3. PERFORMANCE

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

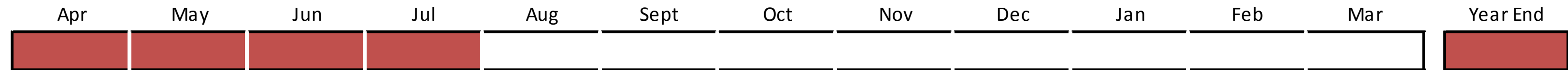
Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	Unrated (blank)	Previous Mth	Awaiting Target	Total
NHS Constitution	11	13	10	10	3	1	0	0	24
Outcomes Framework	11	7	7	8	11	21	8	1	37
Mental Health	21	21	8	8	4	4	0	0	33
Totals	43	**41**	25	**26**	18	**26**	8	**1**	**94**

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	Unrated (blank)	Previous Mth:	Awaiting Target
NHS Constitution	46%	54%	42%	42%	13%	4%	0%	0%
Outcomes Framework	30%	19%	19%	22%	30%	57%	22%	3%
Mental Health	64%	64%	24%	24%	12%	12%	0%	0%
Totals	46%	**44%**	27%	**28%**	19%	**28%**	9%	**1%**



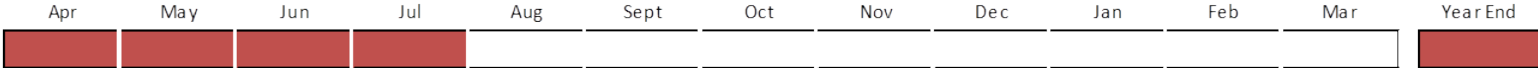
Exception highlights were as follows;

18 Weeks Referral To Treatment (RTT) Incompletes :



The performance data for headline level RTT (Incompletes) was not submitted at Month 4. At time of submission the Trust confirmed that this was due to "On-going validation" of waiting lists. The July performance has since been confirmed for the Royal Wolverhampton Trust via the National Unify 2 submission as 91.18% with 3,128 (out of 35,471) patients waiting more than 18 weeks. The Trust have confirmed that performance has been affected by demand and capacity issues including an increase in referrals, staff sickness and failed recruitment to posts (no applications, declined offers and non appointable applicants). Recovery Action plans have been received from the Trust for General Surgery, Gynaecology, Orthopaedics, Plastic Surgery and Urology. Actions include on-going weekly validation of waiting lists with reviews of paused clocks on waiting lists, patients fit for surgery and diagnostic waiting times. The RTT team are working to forecast priority patients and identify potential bottle necks. The current long waiters for Orthodontics are affecting headline performance and exclusion of the Orthodontics patients (over 18 week waiters) would bring performance to 91.77% and closer to target. The Trust have confirmed that patients affected by the Junior Doctors Industrial Strike Action that took place in April are no longer part of the incomplete pathway figures. Early indications are that the August performance remains below the STF Trajectory at 91.2%. The CCG performance for July has been confirmed as 91.6% with 2 patients waiting over 52 weeks, however, it is important to note that Walsall did not submit the July RTT figures to Unify which may impact on the CCG performance percentage.

A&E 4 hr Waits :



The A&E 4 Hour Wait performance has failed to meet the 95.00% national target since August 2015. Month 4 (July) has seen a decline in performance to 88.63%. The Trust failed to achieve the STF recovery trajectory and both Type 1 and the combined All Types target for the month. A Remedial Action Plan (RAP) has been received from the Trust with updates on actions including : Completion of Urgent Care Centre (UCC) "Streamer" role across opening hours, additional nurse recruitment (to start September) with 5 vacancies remaining. Human Factors Project events have been held with positive feedback, an action plan based on the events outputs is to be finalised by mid September. The Daily UCC/A&E combined activity reporting has been incorporated from 1st August. The 1st Assessment continues to be an issue (workforce related) with an occasional issue of bed capacity. The joint integrated triage system commenced from the 1st week of September and early indications are that the dual system is working well with awareness of the UCC provision improving and relationships continuing to grow between the areas. New methods of data collection have been challenging but data can now be obtained to show how many patients presented to the Emergency Department (ED) and were streamed upstairs to the UCC and how many were diverted back to the ED as acuity was too severe for the UCC. Following the development of the frequent attenders project (with the CCG and WMAS) the Emergency Department Group Manager has met with CCG colleagues and further meetings are planned. Early indications are that the August performance (excluding UCC Vocare) remains below 90% (88.20%). With the inclusion of Vocare performance improves to 90.30% but still breaches the STF Trajectory for July (92.91%).The SRG have successfully transitioned to the AE Delivery Board on 14th September with any outstanding SRG actions/risks aligned to either AE Delivery Board, AE Operational Group, Other (includes RTT and Cancer Waits to be transferred to CRM) or Closed. The Terms of Reference for both groups are currently being developed and are to be ratified at the next AE Delivery Board.

NHS
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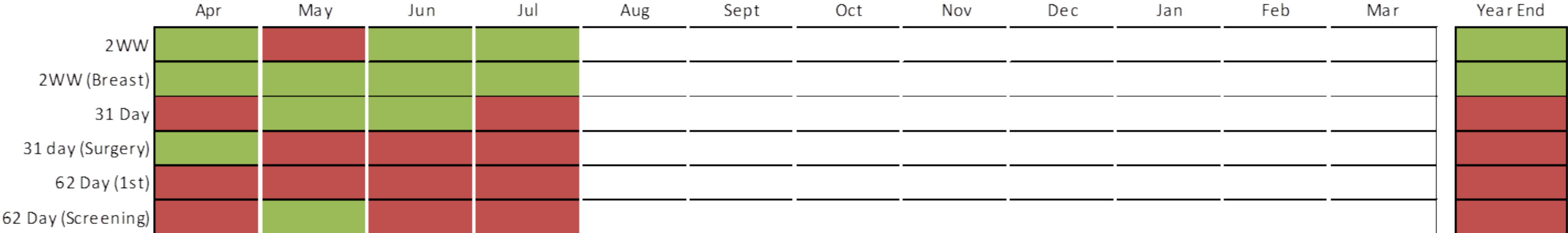
Cancer Waits



RWT_EB6, RWT_EB7, RWT_EB8, RWT_EB9, RWT_EB12 & RWT_EB13

In month breaches for Cancer Waits for July 2016 are:

31 Day (1st Definitive) - 95.36% against 96% target. Validate figures now confirm July performance as 96.4% and within target.

31 Day (Treatment is Surgery) – 89.47% against 94% target. Validated figures now confirm July performance as 92.1% and still below target.

62 Day (1st Definitive Treatment) – 79.77% against 85% target. Validated figures now confirm July performance as 82.2% and still below target.

62 Day (Screening) – 84.00% against 90% target (in-month) and the YTD remains RED (86.00%). Validated figures now confirm July performance as 92.3% and within target.

RWT_LQR1 & RWT_LQR2

E-Discharge

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year End
Excl Assessment													
All													

Performance for E-Discharges is split into 2 indicators:

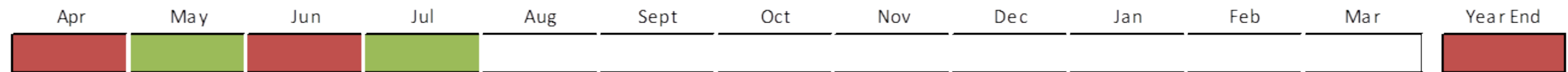
94.29% against a target of 95% - Completion within 24 hours for all wards excluding assessment units

82.94% against a target of 95% - Completion within 24 hours for all assessment units

The performance by unit for July has been confirmed as follows : AMU - 94.16% (Increase), MATY - 87.99% (Increase), GAU - 86.67% (Increase), PAU - 81.62% (Decrease) and SEU - 73.82% (Decrease).

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.

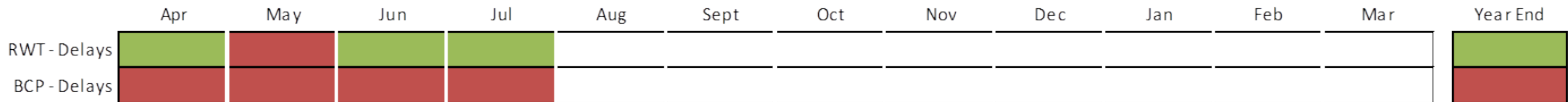
Early Intervention in Psychosis programmes: % of Service Users (>50%) experiencing a first episode of psychosis who commenced a NICE-concordant package of care within two weeks of referral



This indicator has achieved the 50% target for July with 60% of service users commencing a NICE-concordant package of care within 2 weeks of referrals (numerator = 3, denominator =5), however the Year end performance remains below target at 40.38%. An Action Plan has been received from which incorporates new guidance regarding packages of care which have a delayed agreement. A CVO is in preparation for the indicator to reflect 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. The Trust are to re-visit the demand and capacity required to deliver the Early Intervention in Psychosis (EIP) service on the new age range foot print and re-fresh the business case accordingly via the Task and Finish Group.

DNAs are expected with this client group due to the nature of the difficulties they experience and the team are making every effort to address these and continue to gather information from clients who don't attend initial assessments in order to inform any changes that may need to be considered in the assessment process. The team continue to send text messages and call new clients to remind them about their appointments as well as sending out appointment letters. The Trust have previously confirmed reasons for not meeting the 10 day target this month were down to patient choice as the clients had other commitments and asked for their appointments to made after the 10 days (CAMHS appointments requesting appointments beyond the target due to school commitments and patients choice). The CCG will continue to monitor the August/September performance to assess if improvements continue or if affected by the summer and school holiday season.

Delayed Transfers of Care (DTOC)



RWT met the in month stretch target of 3.20% in July, with performance at 1.29%. The Trust have indicated the following top 3 delay reasons for July:
36.4% - Delay Awaiting Assessment (previously 37.3%)
29.1% - Delay awaiting domiciliary package (previously 20.9%)
12.7% - Delay awaiting further NHS Care (previously 19.0%)

The Black Country Partnership Foundation Trust has failed to meet the 7.50% target for the 4th consecutive month with the reported performance of 14.00% for July. The Trust has highlighted 3 key areas that impact on delays:
- An acute lack of appropriate step down placements
- Reluctance of the Local Authority to agree expensive aftercare, some taking months to process and are still not resolved
- Lack of service for individuals with no recourse to public funds (currently the Trust will not discharge unless the patient has an address)

RWT_LQR3 & BCPFT_LQGE11

Performance Indicators 16/17

Current Month: Jul

Key:

(based on if indicator required to be either Higher or Lower than target/threshold)

- ⇧ Improved Performance from previous month
- ⇩ Decline in Performance from previous month
- ⇨ Performance has remained the same

Area	16-17 Reference	Description - Indicators with exeception reporting highlighted for info	Provider	Target	Latest Month Performance	In Mth RAG	YTD Performance	YTD RAG	Trend
NHS Constitution	RWT_EB4	Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test*	RWT	99%	99.01%	G	99.11%	G	⇩
NHS Constitution	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*	RWT	95%	88.63%	R	88.34%	R	⇩
NHS Constitution	RWT_EB6	Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment*	RWT	93%	94.91%	G	93.52%	G	⇧
NHS Constitution	RWT_EB7	Percentage of Service Users referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment*	RWT	93%	93.53%	G	95.40%	G	⇧
NHS Constitution	RWT_EB8	Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers*	RWT	96%	95.36%	R	95.52%	R	⇩
NHS Constitution	RWT_EB9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery*	RWT	94%	89.47%	R	88.43%	R	⇧
NHS Constitution	RWT_EB10	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen*	RWT	98%	100.00%	G	99.62%	G	⇨
NHS Constitution	RWT_EB11	Percentage of Service Users waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy	RWT	94%	96.30%	G	98.36%	G	⇩
NHS Constitution	RWT_EB12	Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer*	RWT	85%	79.77%	R	78.26%	R	⇩
NHS Constitution	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*	RWT	90%	84.00%	R	86.00%	R	⇧
NHS Constitution	RWT_EBS1	Mixed sex accommodation breach*	RWT	0	0.00	G	0.00	G	⇨
NHS Constitution	RWT_EBS2	All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice*	RWT	0	0.00	G	0.00	G	⇨
NHS Constitution	RWT_EAS4	Zero tolerance methicillin-resistant Staphylococcus aureus*	RWT	0	0.00	G	0.00	G	⇨

Trend (null submissions will be blank) per Month: A M J J A S O N D J F M | Yr End

Area	16-17 Reference	Description - Indicators with exeception reporting highlighted for info	Provider	Target	Latest Month Performar	In Mth RAG	YTD Performance	YTD RAG	Trend	Trend (null submissions will be blank) per Month A M J J A S O N D J F M	Yr End
NHS Constitution	RWT_EAS5	Minimise rates of Clostridium difficile*	RWT	2.92 (mth) 35 (Yr End)	7.00	R	20.00	R			
NHS Constitution	RWT_EBS4	Zero tolerance RTT waits over 52 weeks for incomplete pathways*	RWT	0	64.00	R	164.00	R			
NHS Constitution	RWT_EBS7a	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes*	RWT	0	87.00	R	253.00	R			
NHS Constitution	RWT_EBS7b	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes*	RWT	0	5.00	R	13.00	R			
NHS Constitution	RWT_EBS5	Trolley waits in A&E not longer than 12 hours*	RWT	0	0.00	G	0.00	G			
NHS Constitution	RWT_EBS6	No urgent operation should be cancelled for a second time*	RWT	0	0.00	G	0.00	G			
NHS Constitution	RWTCB_S10C	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE, as defined in Contract Technical Guidance	RWT	95%	95.21%	G	95.09%	G			
NHS Constitution	RWTCB_S10B	Duty of candour	RWT	Yes	Yes	G	-	R			
NHS Constitution	RWTCB_S10D	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	RWT	99.00%	99.59%	G	99.57%	G			
NHS Constitution	RWTCB_S10E	Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	RWT	95.00%	97.14%	G	97.03%	G			
Outcomes Framework	RWT_LQR1	Electronic discharge summary to be fully completed and dispatched within 24 hours of discharge for all wards excluding assessment units.	RWT	95.00%	94.29%	R	93.78%	R			
Outcomes Framework	RWT_LQR2	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	95.00%	82.94%	R	84.85%	R			
Outcomes Framework	RWT_LQR3	Delayed Transfers - % occupied bed days - to exclude social care delays	RWT	Q1 - 3.5% Q2 - 3.2% Q3 - 2.8% Q4 - 2.5%	1.29%	G	2.44%	G			
Outcomes Framework	RWT_LQR4	Serious incident (SI) reporting – SIs to be reported no later than 2 working days after the incident is identified.	RWT	0	0.00	G	2.00	R			
Outcomes Framework	RWT_LQR5	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	0	0.00	G	4.00	R			

Area	16-17 Reference	Description - Indicators with exeception reporting highlighted for info	Provider	Target	Latest Month Performar	In Mth RAG	YTD Performance	YTD RAG	Trend	Trend (null submissions will be blank) per Month A M J J A S O N D J F M	Yr End
NHS Constitution	RWT_EAS5	Minimise rates of Clostridium difficile*	RWT	2.92 (mth) 35 (Yr End)	7.00	R	20.00	R			
NHS Constitution	RWT_EBS4	Zero tolerance RTT waits over 52 weeks for incomplete pathways*	RWT	0	64.00	R	164.00	R			
NHS Constitution	RWT_EBS7a	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes*	RWT	0	87.00	R	253.00	R			
NHS Constitution	RWT_EBS7b	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes*	RWT	0	5.00	R	13.00	R			
NHS Constitution	RWT_EBS5	Trolley waits in A&E not longer than 12 hours*	RWT	0	0.00	G	0.00	G			
Outcomes Framework	RWT_LQR6	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	0	1.00	R	7.00	R			
Outcomes Framework	RWT_LQR7	Number of cancelled operations - % of electives	RWT	0.80%	0.43%	G	0.55%	G			
Outcomes Framework	RWT_LQR8	Hospital GSF - % patients recognised as end of life are on the GSF register within the hospital.	RWT	95.00%	100.00%	G	100.00%	G			
Outcomes Framework	RWT_LQR14	Stroke - Percentage of patients who spend at least 90% of their time on a stroke unit	RWT	80.00%	93.48%	G	90.27%	G			
Outcomes Framework	RWT_LQR15	Stroke - Percentage of higher risk TIA cases are assessed and treated within 24 hours	RWT	60.00%	58.82%	R	68.08%	G			
Outcomes Framework	RWT_LQR17	Best practice in Day Surgery - outpatient procedures - % of Day case procedures that are undertaken in an Outpatient setting	RWT	90.00%	94.22%	G	93.12%	G			
Outcomes Framework	RWT_LQR18ai	Optimising Outpatient Follow-Ups - 2015/16 - Prostate cancer patients receiving telephone follow up clinic: Prostate Biopsy Follow up ≥ 4 patients per month	RWT	4	11.00	G	39.00	G			
Outcomes Framework	RWT_LQR18aii	Optimising Outpatient Follow-Ups - 2015/16 - Prostate cancer patients receiving telephone follow up clinic: Prostate Cancer Follow up ≥ 17 patients per month	RWT	17	42.00	G	129.00	G			
Outcomes Framework	RWT_LQR18b	Optimising Outpatient Follow-Ups - Paediatric Rheumatology and Paediatric Endocrinology patients receiving telephone follow up clinic ≥ 30 per month	RWT	30	20.00	G	97.00	R			
Outcomes Framework	RWT_LQR18c	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	50	2.00	G	15.00	R			
Outcomes Framework	RWT_LQR20	% Patients in receipt of TTOs within 4hours from the pharmacy receiving order	RWT	TBC	97.96%		96.70%	Awaiting Target			

Area	16-17 Reference	Description - Indicators with exeception reporting highlighted for info	Provider	Target	Latest Month Performance	In Mth RAG	YTD Performance	YTD RAG	Trend
Mental Health	BCPFT_EB3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral*	BCP	92.00%	99.05%	G	98.76%	G	
Mental Health	BCPFT_EBS1	Mixed sex accommodation breach	BCP	0.00	0.00	G	0.00	G	
Mental Health	BCPFT_EBS3	Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care*	BCP	95.00%	100.00%	G	96.04%	G	
Mental Health	BCPFT_EBS4	Zero tolerance RTT waits over 52 weeks for incomplete pathways	BCP	0.00	0.00	G	0.00	G	
Mental Health	BCPFT_DC1	Duty of Candour	BCP	Yes	Yes	G	-	G	
Mental Health	BCPFT_IAPT1	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance	BCP	90.00%	100.00%	G	100.00%	G	
Mental Health	BCPFT_EH4	Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis who commenced a NICE-concordant package of care within two weeks of referral	BCP	50.00%	60.00%	G	40.83%	R	
Mental Health	BCPFT_EH1	Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who are treated within six weeks of referral	BCP	75.00%	95.36%	G	90.64%	G	
Mental Health	BCPFT_EH2	Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who are treated within 18 weeks of referral	BCP	95.00%	100.00%	G	99.72%	G	
Mental Health	BCPFT_LQGE01a	Proportion of Patients accessing MH services who are on CPA who have a crisis management plan (people on CPA within 4 weeks of initiation of their CPA)	BCP	90.00%	100.00%	G	100.00%	G	
Mental Health	BCPFT_LQGE01b	Percentage of inpatients with a Crisis Management plan on discharge.	BCP	100.00%	100.00%	G	100.00%	G	
Mental Health	BCPFT_LQGE02	Percentage of EIS caseload have crisis / relapse prevention care plan	BCP	80.00%	85.71%	G	84.01%	G	
Mental Health	BCPFT_LQGE03	Meeting commitment to serve new psychosis cases by early intervention teams. Quarterly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance rounded down. (Monitor definition 11)	BCP	44.00	14.00	G	31.00	G	
Mental Health	BCPFT_LQGE04	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	BCP	50.00%	60.00%	G	40.83%	R	

Trend (null submissions will be blank) per Month: A M J J A S O N D J F M | Yr End

Area	16-17 Reference	Description - Indicators with exeception reporting highlighted for info	Provider	Target	Latest Month Performar	In Mth RAG	YTD Performance	YTD RAG	Trend	Trend (null submissions will be blank) per Month A M J J A S O N D J F M	Yr End
Mental Health	BCPFT_LQGE05	Percentage of all routine EIS referrals, receive initial assessment within 10 working days	BCP	95.00%	100.00%	G	84.38%	R	⇨		
Mental Health	BCPFT_LQGE06	IPC training programme adhered to as per locally agreed plan for each staff group. Compliance to agreed local plan. Quarterly confirmation of percentage of compliance	BCP	85.00%	93.29%	G	93.70%	G	⇧		
Mental Health	BCPFT_LQGE09	Evidence of using HONOS: Proportion of patients with a HONOS score	BCP	95.00%	95.32%	G	95.31%	G	⇩		
Mental Health	BCPFT_LQGE10	Proportion of patients referred for inpatient admission who have gatekeeping assessment (Monitor definition 10)	BCP	95.00%	100.00%	G	100.00%	G	⇨		
Mental Health	BCPFT_LQGE11	Delayed transfers of care to be maintained at a minimum level	BCP	7.50%	14.00%	R	12.63%	R	⇩		
Mental Health	BCPFT_LQGE12	Emergency up to 4 hours. % of assessments relating to referral within period	BCP	85.00%	90.83%	G	90.29%	G	⇧		
Mental Health	BCPFT_LQGE13	Urgent (up to 48 hours). % of assessments relating to referral within period	BCP	85.00%	86.27%	G	82.57%	R	⇧		
Mental Health	BCPFT_LQGE14	Routine (up to 28 days). % of assessments relating to referral within period	BCP	85.00%	97.67%	G	97.38%	G	⇩		
Mental Health	BCPFT_LQGE15	Percentage of SUIs that are reported onto STEIS within 2 working days of notification of the incident	BCP	100.00%	100.00%	G	100.00%	G	⇨		
Mental Health	BCPFT_LQGE16	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.	BCP	100.00%	100.00%	G	96.43%	R	⇨		
Mental Health	BCPFT_LQGE17	Provide commissioners with Grade 1 and Grade 2RCA reports within 60 working days where possible, exception report provided where not met	BCP	100.00%	100.00%	G	100.00%	G	⇨		
Mental Health	BCPFT_DB01	Safeguarding – failure to achieve thresholds for specific indicators as detailed in the Safeguarding Dashboard.	BCP	Yes	No	R	-	R			
Mental Health	BCPFT_DB02	CAMHS - failure to achieve thresholds for specific indicators as detailed in the CAMHS Dashboard.	BCP	Yes	No	R	-	R			
Mental Health	BCPFT_DB03	IAPT – failure to achieve thresholds for specific indicators as detailed in the IAPT Dashboard.	BCP	Yes	Yes	G	-	G			
Mental Health	BCPFT_DB04	Dementia Data Set – failure to complete the Dementia Data Set	BCP	Yes	Yes	G	-	G			

Wolverhampton Clinical Commissioning Group

Additional Dashboards (National Reporting)

Area	16-17 Reference	Description - Indicators with exeception reporting highlighted for info	Provider	Target	Latest Month Performance	In Mth RAG	YTD Performance	YTD RAG	Variance between Mth	Trend (null submissions will be blank) per Month
IAPT	BCP_32	The number of people who have entered (ie received) psychological threrapies during the reporting period	BCP	366	366	G	1629	G	⇩	
IAPT	BCP_55	People who have entered (ie received) treatment as a proportion of people with anxiety or depression	BCP	15.00%	0	R	0	R	⇧	
IAPT	LQIA01	Percentage of people who are moving to recovery of those who have completed treatment in the reporting period	BCP	50%	51.72%	G	53.08%	G	⇧	
IAPT	LQIA02	75% of people engaged in the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral [Target - >75%	BCP	75%	95.36%	G	90.64%	G	⇧	
IAPT	LQIA03	95% of people referred to the Improved Access to Psychological Therapies programme will be treated within 18 weeks of referral [Target - >95%	BCP	95%	100.00%	G	99.72%	G	⇨	
IAPT	LQIA04	Percentage achievement in data validity across all IAPT submissions on final data validity report [Target - >80%	BCP	80%	No Data	No Data	84.35%	G		
IAPT	LQIA05	People who have entered treatment as a proportion of people with anxiety or depression (local prevalence) [Target - Special Rules - 2524 = 15% of prevalence. Annual target for High Intensity and Counselling	BCP	5%	1.25%	R	1.39%	R	⇩	

4. RISK and MITIGATION

Finance

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. 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.

5. RECOMMENDATIONS

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

Name: **Claire Skidmore**
Job Title: **Chief Finance and Operating Officer**
Date: **28 September 2016**

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Wolverhampton Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
11 OCTOBER 2016

Agenda item 13

Title of Report:	**Summary – Primary Care Joint Commissioning Committee 6 September 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 6 September 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 6 September 2016. This report provides a summary of the issues discussed and the decisions made at those meetings.

6 SEPTEMBER 2016 COMMITTEE MEETING

2. PRIMARY CARE UPDATES

The Committee received the following update reports:-

- **NHS England**
  The Committee was informed that the deadline for applications for the CCG to become fully delegated was 5 December 2016. The outcome of the approval process will be communicated in January 2017 with a go live date for the new delegated arrangements commencing from 1 April 2017.

- **Wolverhampton CCG Update**
  An update was provided on the Estates and Technology Transformation Fund and it was stated that the outcome of all bid applications will be received by November 2016 and therefore no commitments can be made until the outcomes are received.

  It was highlighted that positive feedback has been received in relation to the Local Digital Roadmap plans which have been submitted. Good stakeholder relationships have been made and the plan is making good progress prior to being submitted.

- **Primary Care Programme Board**
  An overview was provided regarding the delivery of the work being undertaken by the Primary Care Programme Board. It was highlighted that the Interpreting Procurement closing date had been extended until 30 August 2016 and a review of the bidders will take place during September 2016. The new contract will commence on 1 December 2016.

  Following discussion at the August 2016 Commissioning Committee regarding the Community Equipment Procurement it was agreed that WCCG would go ahead and procure their own services.

- **Primary Care Operations Management Group (PCOMG) Update**
  An overview of the key areas covered at the Primary Care Operational Management Group Meeting was provided. Discussion took place around whether the Group were satisfied with the percentage of returns and feedback

with regards to Friends and Family Test results. It was noted that there are 2 GP practices who fail to submit data and the PCOMG have agreed to allow one month to improve performance.

3. OTHER ISSUES CONSIDERED

3.1 The Committee reviewed the amended Terms of Reference. The main changes are the inclusion of the Lay Member for Finance and Performance within the Committee membership (Deputy Chair) and that GP members no longer have formal voting rights. Clarification of the CCG's requirements around registration of interest applying to NHS West Midland representatives was also included.

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:	27 September 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**	**27/09/16**

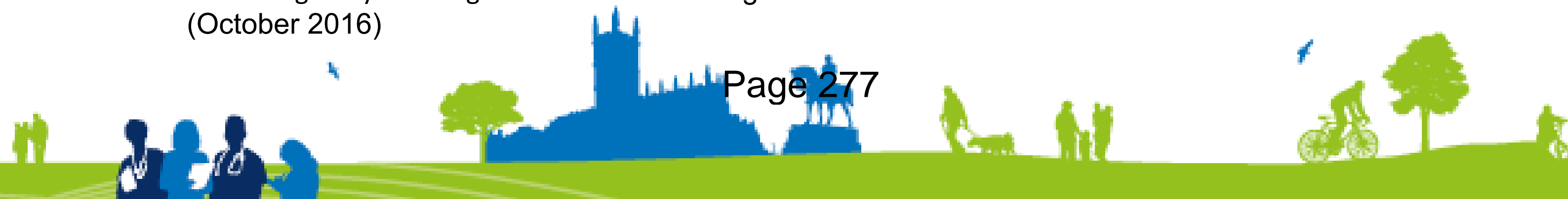
NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body – 11 October 2016

Agenda item 14

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:- • Formation of a Primary Care Strategy Committee & associated governance structure • Program of Work Delivery Update • Emerging New Models of Care Reports will be provided on a monthly basis hereafter to ensure the Governing Body are kept appraised of progress 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 July 2016 the Primary Care Strategy Committee was formed, in line with the plan for implementation. The committee has met in July, August & September with the intention for meetings to be held on a monthly basis thereafter in line with the agreed terms of reference. The function of the committee is to have oversight of an extensive transformation program focussing on care provided in primary care now and in the future.

2.2. A corresponding governance structure has been compiled and can be found at appendix 1, this provides clarity regarding the inter-dependencies between other associated forums also providing direct reports into the Governing Body pertaining to the primary care agenda. The committee will provide reports on a monthly basis to the Governing Body hereafter.

2.3. An extensive program of work has been defined to underpin the successful delivery of the Primary Care Strategy and comprises of a series of task and finish groups as follows:-

- Practices as Providers
- Localities as Commissioners
- Primary Care Contracting
- Workforce Development
- Clinical Pharmacists in Primary Care
- Estates
- Information Technology

Each of the above has been formed in line with the CCGs program management office approach. All work streams have a series of objectives & timescales for delivery that are overseen by the committee. Highlight reports are prepared by the work stream lead(s) following each meeting for consideration at the Primary Care Committee, exceptions will be reported with corresponding remedial actions identified by the task and finish group for consideration by the committee.

2.4 Whilst this program of work is in its infancy there are a series of items that have been achieved at this early stage including:-

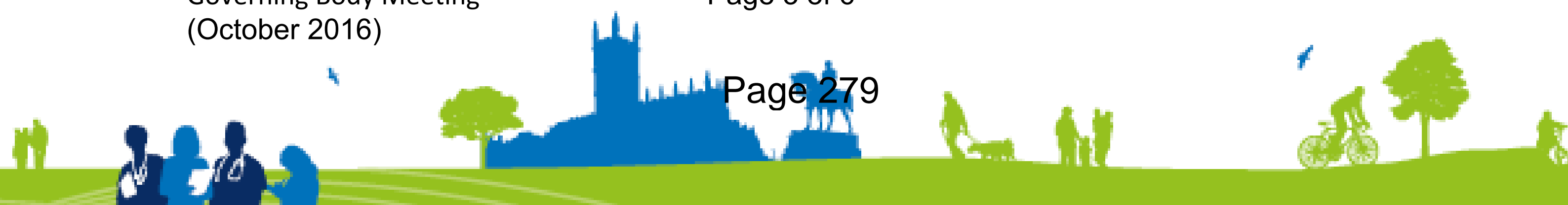
- Formation of a Primary Care Joint Committee
- Formation of a Primary Care Operational Management Group
- Project Management Support assigned to Primary Care Home Model
- Review of enhanced primary care services
- Investment Plan for Primary Care Reserves Funding
- Introduction of a Clinical Reference Group
- Development of a Primary Care Service Costing Template
- Primary In Reach Service specified & implemented
- Gap Analysis of Primary Care workforce needs & responsive plan
- Collaborative approach to contract review visits using a standardised process & tool
- Proposals submitted for Estate Transformation Fund
- Baseline survey of estate completed
- Estate Strategy developed & implementation commenced
- Work with Primary Care Home test site(s) to investigate technological solutions

There are many other items from the work program that have commenced and will be measured in line with the critical path that has been assigned to each component.

2.5 In order to sustain primary medical services in Wolverhampton, and in line with the CCG members' decision to pursue the Multi-speciality Care Provider (MCP) Framework, groups of practices are aligning themselves in readiness to deliver against the framework from April 2017, as can be seen in Appendix 2.

In August an application was made to the National Association of Primary Care from Wolverhampton Care Collaborative, with support from the CCG. This is the second group of practices who have come together with the intention to adopt the Primary Care Home Model. Other groups are intending to function as 'Medical Chambers' or an 'Alliance', where they intend to fulfil the requirements of an MCP contract whereby each practice will sign up to a Memorandum of Understanding (MoU) with the practices included in their group. Each group will be responsible for serving the commissioned needs of their registered population. More detail on the logistics of this contracting model will be provided following further guidance due to be published at the end of September.

2.6 Also in August, a report was provided to the Primary Care Joint Commissioning Committee with a corresponding action plan detailing each of areas of action arising from the General Practice Five Year Forward View. A copy of the action plan can be found at Appendix 3.



3. CLINICAL VIEW

3.1. There are a range of clinical and non-clinical professionals leading this process in order to ensure that the leadership decisions are clinically driven.

4. PATIENT AND PUBLIC VIEW

4.1. 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.

5. RISKS AND IMPLICATIONS

Key Risks

5.1 The Primary Care Strategy Committee has in place a risk register that has begun to capture the profile of risks associated with the programme 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

5.2 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

5.3 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

5.4 The Strategy has a full equality analysis in place. This will require periodic review during the implementation phase.

Medicines Management Implications

5.5 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

5.6 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.

6 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 September 2016

Enclosures:-

Appendix 1 Primary Care Strategy Governance Structure
Appendix 2 New Models of Care
Appendix 3 General Practice Five Year Forward View Action Plan

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	27.9.16
Public/ Patient View	Pat Roberts	27.9.16
Finance Implications discussed with Finance Team	Claire Skidmore	27.9.16
Quality Implications discussed with Quality and Risk Team	Manjeet Garcha	27.9.16
Medicines Management Implications discussed with Medicines Management team	David Birch	27.9.16
Equality Implications discussed with CSU Equality and Inclusion Service	Juliet Herbert	27.9.16
Information Governance implications discussed with IG Support Officer	NA	
Legal/ Policy implications discussed with Corporate Operations Manager	Steven Marshall	27.9.16
Signed off by Report Owner (Must be completed)	Steven Marshall	27.9.16

General Practice 5 Year Forward View
Summary of Requirements

NHS
Wolverhampton
Clinical Commissioning Group

<table>
<tr><th>Chapter</th><th>Lead</th><th>Headline</th><th>Action</th></tr>
<tr><td rowspan="3">Chapter 1</td><td rowspan="3">Claire Skidmore</td><td>CCG Budgets</td><td>Primary Care "national must do" to incorporat Primary Care into our STP work
If we assume that we take a capitated share of the £171m requirement from CCGs this would be a cost to the CCG in the region of £850k. (£170k per annum growth over 5 yrs)
• Increase in GPIT monies this year of 18%. Don't know if this refers to HSCIC (central) money but we kept our figure static this year…
• BCF is noted as an avenue for expanded services – new rules this year allow this
• £s required for protected learning time and backfill for GP development (chapter 5)
• Other implications of developments in GP IT, paper free practices, E-prescribing etc
CCG Action : Awaiting further clarification</td></tr>
<tr><td>Other Pots of Money</td><td>• £10m for vulnerable practices (announced in 2015). Requires match funding from practices. Not got any practices in Wolves in 2016/17.
• £x transitional funds for premises May to Oct '16 (chapter 4)
• Up to £45m to support the uptake of online consultation systems in 17/18 (chapter 4)
• £x in addition to core IT, CCGs will also have access to funding for subsidiary technology services (with a view that these become core) (chapter 4)
• £3.5m multidisciplinary training hubs
• £x other existing avenues for bursaries, fellowships etc
CCG Action : Awaiting further clarification</td></tr>
<tr><td>Other</td><td>Review of Carr-Hill formula (DoH and BMA). Work to be concluded summer '16
CCG Action: none at the moment, await further information. [nb, potential cost pressure if practice funding increases but allocations are not amended]

CCG must publish plans for PMS monies reinvestment before the full impact of the switch to GMS is taken by the affected practices
CCG Action: CCG must agree how the monies will be invested and publish the results

Indemnity – DoH and NHSE to put reform proposals to stakeholders in July '16
CCG Action: none at the moment, await further information</td></tr>
<tr><td>Chapter 2 Workforce</td><td>Manjeet Garcha</td><td>Focus on Primary Care workforce
• Training
• Recruitment
• Retention
• Return 2 practice

£508m over the next 5 years to support struggling practices, further develop workforce, tackle workload and stimulate care design.</td><td>Workforce Measures
• Double growth rate in GPs with a further 5000 net GPs in next 5 years through training, recruitment and R2P. This includes recruiting more than 500 overseas GPs.
• Investment in 3000 new fully funded practice based mental health therapists by 2020/21 (an average of a full time therapist for every 2-3 typically sized GP practices).
• Plans to provide £112m for a further 1500 co funded practice clinical pharmacists with aim of having 1:30,000 population by 2020.
• Primary Integration Fund
• £15m for practice nurse development
• £45m over 5 years for practices to support the training of reception and clerical staff to play a greater role in navigation of patients.
• £6m for practice manager development
• Investment by HEE in training of 1000 physician associates to support general practice
• £16m ?? have seen two figures for this £56m and £16m to mental health support for GPs access to 'free, confidential local support and treatment for mental health issues' to tackle stress and burnout. This scheme to start from Dec 2016 with procurement to commence June 2016.
CCG Action : Awaiting further information from NHS England Workforce Lead</td></tr>
</table>

Chapter 3 Workload	Helen Hibbs	30 million releasing time for patients Development programme (Cross reference Chapter 5)	Funding will flow through CCGs for new ways of working including demand management, workforce, skill mix and technology. Community pharmacy and interoperability of technology. **CCG Action : Local Workforce Task and Finish Group to continue discussions & act on further advice/guidance from NHS England in due course**
		By September 16	National programme for Care planning for patients with long term conditions. **CCG Action : Continue work already underway in order to fully implement at locality level**
		NHS 111	Flow(s) into hubs, social prescribing and minor ailment schemes **CCG Action : Continue work already underway & await further guidance**
		Practice Resilience	£10million for 800 already identified vulnerable practices **CCG Action : Response provided to NHSE in collaboration with LMC, awaiting outcome**
		40 million with 16 million in 16/17	Combined NHS ENGLAND and RCGP work on practice resilience teams **CCG Action : Awaiting further information**
Chapter 4 Practice Infra-structure	Mike Hastings	Estates	• Changing premises cost directions to ensure that up to 100% of the cost of premises development can be funded through NHSE capital investment. • Allowing support for Capital schemes over more than one year • Investment in 'at scale' project support to assist with legal, financial and design elements of project. • Additional support offered for practices with costs relating to Stamp Duty, VAT and transitional support with additional facilities management costs on NHSPS leases. Guidance is awaited on how this will work in practice. • Estates Strategy to address both premises in need of improvement and the overall efficiency of usage of the local estate. **CCG Action : Continue with work/discussions already taking place**
		Technology	The additional GP IT funding includes £45 million to improve uptake of online consultation systems and a greater range of core requirements are being introduced to outline the services that should be provided to practices. These include:- • Access to records inside and outside of practice premises • Specialist support for IG, IT/cyber security, data quality, training etc. • An Annual practice IT review • SMS messaging • Online appointment, repeat prescription and records access facilities • E-Discharge Specialist support and advice on information sharing and consent based records sharing will be available from December 2016. Wi-Fi in practices, a national framework for telephone and e-consultation solutions and funding for education for patients and practitioners on the use of digital solutions. [CCG-Controlled GP IT budget however recent guidance has clarified that a number of these services (including IG support) should be commissioned by the DCO team. Further details are required to determine how much work will be directed and how much we will be expected to deliver] NHSE will be undertaking national work to stimulate the development of appropriate apps and triage solutions etc. across the market to provide an approved range of solutions for local GPs to address patient needs. **CCG Action : Continue with work/discussions already taking place**
		Inter-operability	Primarily to support collaboration between practices (or within integrated systems). Bids for IT projects through the ETT Programme Standards for ways practices work together across different sites and clinical systems National Data Guardians review of data security and consent/opt-outs that will clarify how models for data sharing will work **CCG Action : Continue with work/discussions already taking place**
Chapter 5	Steven	Over £500m to be made	• Self-care and direct access to other services (e.g on line self-management and signposting)

Care Design	Marshall	available by 2020/21 to commission and fund extra capacity	• Better workforce utilisation i.e. ANPs, clinical pharmacists • Physios & medical assistants • Using digital technology ***CCGs will be required to meet minimum requirements before accessing funding& match fund £171m of practice transformational support*** with a view to: • Stimulate the development of ‘at scale’ providers for extended delivery • Implement 10 high impact changes • Underpin financial sustainability to improve in-hours access **CCG Action : Awaiting further information**
		MCP contract	• The provider (i.e. MCP) holds a single whole population budget for services it provides incl. primary medical and community services. • Intent is to take a population health management approach and challenge current “GP appointment, referral or prescription” approach • The vision is for the MCPs to be integrated community based teams (GPs, ***physicians***, Nurses, therapists, pharmacists) with access to intermediate beds, and redesigning pathways out of acute and on into supported community settings • This intends to go live voluntarily April 2017 but has already some key features: ○ MCP defined as an **integrated provider**, with a scope of the services it provides itself & not all Acute & Spec. services ○ Can be CIC, LLP, or JV with local trust ○ New payment model on a capitation based approach ○ ***New blended pay for quality and performance replacing CQUIN & QOF which can be arranged by the MCP itself to meet its own requirements and those of constituent clinicians*** ○ Greater practice integration can mean some activities can take place at MCP level i.e. CQC ○ New procurement process to be introduced to allow MCP contracts to be let on a list based approach • New employment/contractor options offering salaried or equity partnership. Might be instead of GMS/PMS, but these can be held ‘dormant’ and reactivated/right to return • Adopting new contractual arrangements is voluntary • Common practice policies • CPD, clinical governance • Staff training and workforce development • Improved access and new ways of working • Shared back office, shared BI and shared pools of support staff • Stronger voice/power for Primary Care in the system **CCG Action : Awaiting further information, guidance & framework due late July 2016**
		Releasing time for patients	£30m over three years available for all practices, starting in 16/17 Spread innovation (HIA *(Active signposting; New consultation types; Reduce DNAs; Develop team; Productive workflows; Personal productivity; Partnership working; social prescribing; Support self-care; Develop QI expertise)*and address ‘***inequalities in the experience of accessing services’*** Hosting Action Learning Sets Build Change Leadership **CCG Action : Awaiting further information**
		Measuring Workload & Improvement	Provide an online version of a clinical audit tool to identify ways to reduce GP appointments and provide benchmarks Provision of an ‘automated appointment measuring interface’ to measure activity variation over time to allow for balancing of demand and capacity available to all practices from 17/18 (when in year un specified **CCG Action : Awaiting further information**
		Stimulating Local Support	to ‘strengthen arrangements’ for PLT for GP backfill that is the backfill paid for by the CCG. The 3 most successful areas for MCP/provider development: • Creating space for practices to meet & plan • Providing expert facilitation for creating improvement plans • Focusing development on improving care before determining any types of organisational form **CCG Action : Awaiting further information**

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V5 29.9.16

NHS
Wolverhampton
Clinical Commissioning Group

New Models of Care (Wolverhampton)

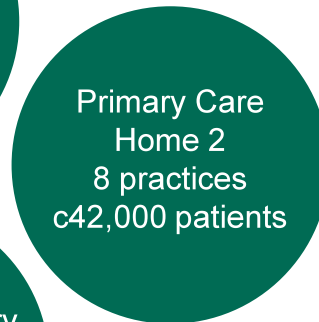
Primary & Acute Care Systems (PACs/VI) is a collaboration between NHS Trusts and GP Practices to meet the needs of registered list(s) of patients. This is an opportunities for trust's to kick-start primary care expansion but reinforce out of hospital care which could evolve into taking accountability 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.

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.

Vertical Integration (VI)

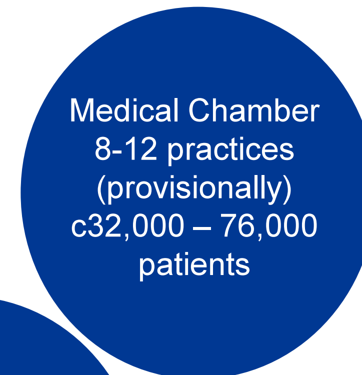
Discussions are on-going with a number of other practices and yet to be confirmed

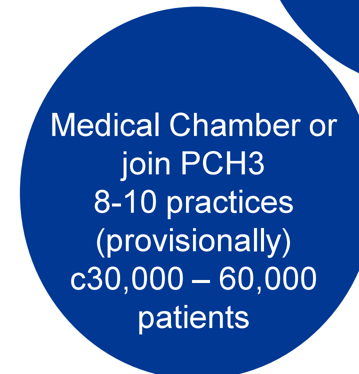
Primary Care Home



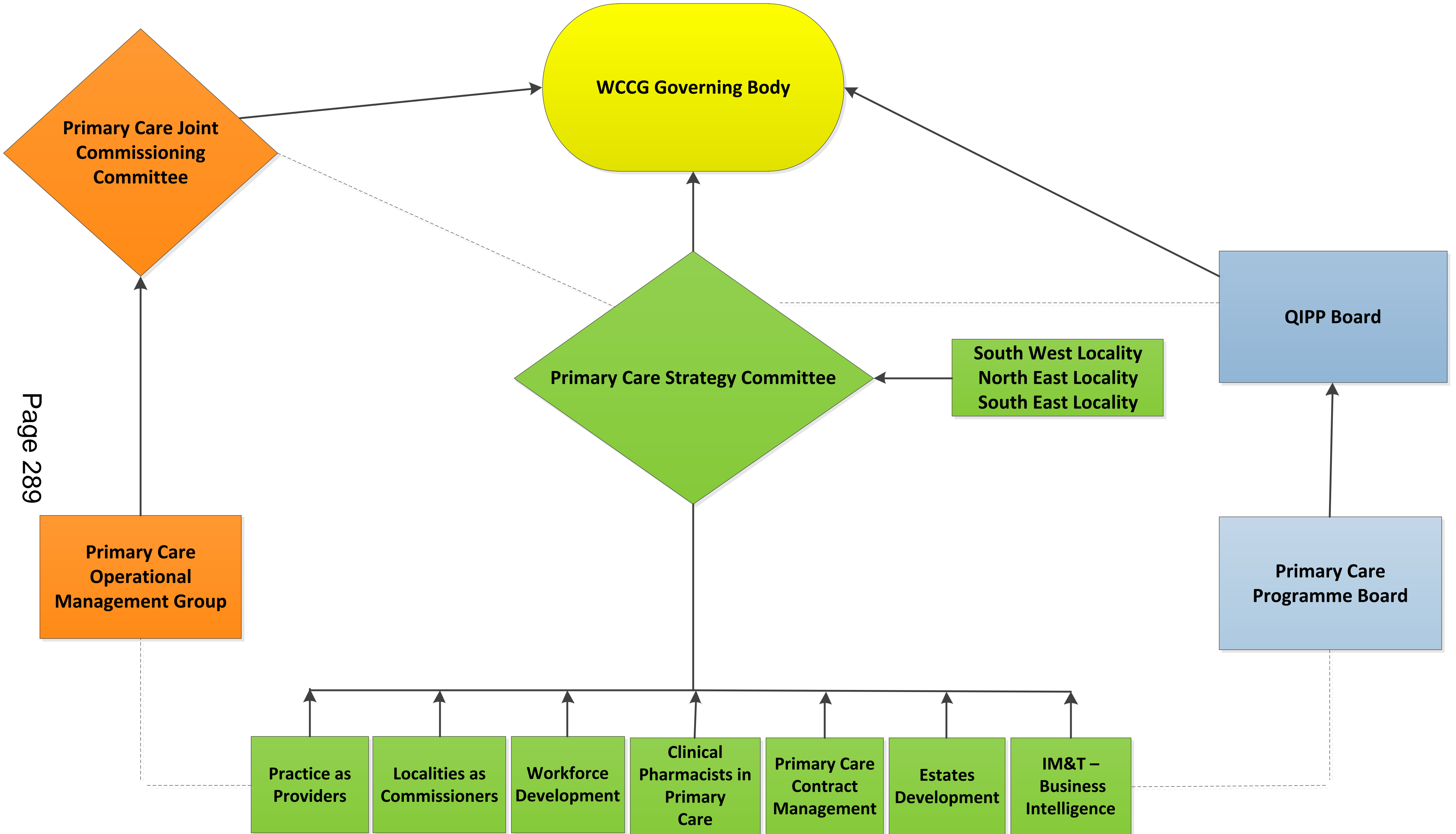
Discussions are on-going with a number of other practices and yet to be confirmed

Alliance / Federation





Discussions are on-going with a number of other practices and yet to be confirmed


Assurance
Strategy
QIPP
Primary Care Joint Commissioning Committee
WCCG Governing Body
QIPP Board
Primary Care Strategy Committee
South West Locality
North East Locality
South East Locality
Primary Care Operational Management Group
Primary Care Programme Board
Practice as Providers
Localities as Commissioners
Workforce Development
Clinical Pharmacists in Primary Care
Primary Care Contract Management
Estates Development
IM&T – Business Intelligence

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body – 11 October 2016

Agenda item 15

Title of Report:	**Communication and Participation update**
Report of:	Pat Roberts – Lay member for PPI
Contact:	Pat Roberts and Helen Cook, Communications & Engagement Manager
Communication and Participation Team Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	This report updates the Governing Body on the key communications and participation activities in July and August June 2016. The key points to note from the report are: 2.1.1 **Patient Transport Services (PTS)** 2.1.2 **Stay Well this Winter**
Public or Private:	This report is intended for the public domain
Relevance to CCG Priority:	
Relevance to Board Assurance Framework (BAF):	1,2,2a,4
• **Domain 1:** A Well Led Organisation	• Involves and actively engages patients and the public • Works in partnership with others
• **Domain 2a:** Performance – delivery of commitments and improved outcomes	• Delivering key mandate requirements and NHS Constitution standards
• **Domain 2b:** Quality	• Improve quality and ensure better outcomes for patients
• **Domain 4:** Planning (Long Term and Short Term)	• Assurance that CCG plans will be a continuous process, covering not only annual operational plans but the 5 Year Forward View and longer term strategic plans including the Better Care Fund.

1. BACKGROUND AND CURRENT SITUATION

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

2. MAIN BODY OF REPORT

Communication – key updates

2.1.1 **Patient Transport Services (PTS)**
Work has begun with Dudley CCG and WMAS to prepare public facing and staff/member communications about the change of provider for PTS in early October.

2.1.2 **Stay Well this Winter**
Planning is well underway for a joint winter campaign this year with both Wolverhampton Public Health Department and Royal Wolverhampton NHS Trust. The first few months will be aimed at flu vaccination uptake and, from November onwards, the campaign will mirror the national stay well campaign until end of March 2016, particularly targeted to pregnant women, children under 5 and those with long term conditions.

2.1.3 **Seven Day Hospital Services**
Working with our colleagues at Royal Wolverhampton Trust (RWT) and NHS England we have developed a joint communications and engagement plan around the seven day hospital services, with which RWT is an early implementer site. Work around informing members has begun with attendance at the Team W and preparation for an event in October.

2.1.4 **Policies of Limited Clinical Value (POLCV)**
Planning has begun to disseminate information about POLCV to local groups and stakeholders. This will take place in October, November and early December 2016.

Communication and Participation framework

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

2.2.2 **Practice Nurse Bulletin**
The eighth edition of the Practice Nurse bulletin went out in September. Topics included: Redesign of current wound care services, MASH update, NHS111 update, training opportunities such as Infection Prevention and Changing roles of social workers, and News from NHS England.

2.2.3 **Practice Managers Forum**
The August meeting discussed varied topics including:

- Health visiting consultation
- Primary Care Support Teams
- Primary Care Team Introductions from CCG
- Concordia – Community Dermatology updates
- First Practice Management – Staff/Practice Training
- Risk Stratification
- Community Matrons
- Telephony systems upgrades
- IT Solutions for practices

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

2.3.1 **Commissioning Intentions**
Planning for next year's round of Commissioning Intentions has begun.

- **LAY MEMBER MEETINGS**

3.1 The Lay Member met with the Vocare representative for the Urgent Care Centre together with a Healthwatch Representative to discuss a specification KPI for a patient survey at the UCC, a draft is being prepared and will be piloted with 150 patients, evaluated and implemented.

4. CLINICAL VIEW

GP members are key to the success of the CCG and their involvement in the decision-making process, engagement framework and the commissioning cycle is paramount to clinically-led commissioning.

5. RISKS AND IMPLICATIONS

None to note

6. RECOMMENDATIONS

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

Name – Pat Roberts
Job Title - Lay member for PPI
Date: 29 September 2016

RELEVANT BACKGROUND PAPERS
(NHS Act 2006 (Section 242) – consultation and engagement
NHS Five Year Forward View – Engaging Local people
NHS Constitution 2016 – patients' rights to be involved
NHS Five year Forward View (Including national/CCG policies and frameworks)

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	**Date**
Clinical and Practice View		
Public / Patient View	**PPG and Citizens Forum**	**September 2016**
Finance Implications discussed with Finance Team		
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	29th September 2016

NHS
Wolverhampton
Clinical Commissioning Group

MINUTES OF THE QUALITY & SAFETY COMMITTEE HELD ON 9TH AUGUST 2016, COMMENCING AT 10.30AM, IN THE MAIN CCG MEETING ROOM, WOLVERHAMPTON SCIENCE PARK.

PRESENT:	Dr R Rajcholan	-	WCCG Board Member (Chair)
	Manjeet Garcha	-	Executive Director of Nursing & Quality
	Nicola Ensor	-	Interim Head of Quality & Risk
	Geoff Ward	-	Patient Representative
	Marlene Lambeth	-	Patient Representative
	Pat Roberts	-	Lay Member Patient & Public Involvement
	Annette Lawrence	-	Quality & Patient Safety Manager
	Philip Strickland	-	Administrative Officer
APOLOGIES:	Jim Oatridge	-	Lay Member, WCCG
	Kerry Walters	-	Governance Lead Nurse, Public Health

1. APOLOGIES & INTRODUCTIONS

Introductions were made and the above apologies were noted by members.

2. MINUTES & ACTIONS OF THE LAST MEETING

2.1 Minutes of the 14th June 2016

The minutes of the meeting held on the 14 June 2016 were approved as an accurate record.

2.2 Action Log from meeting held on the 14th June 2016

The Action Log from the Quality & Safety Committee held on the 14th June 2016 was discussed, agreed and an updated version would be distributed with the minutes of this meeting.

2.3 Comments received from the virtual meeting held on the 12th July 2016

Comments from the Virtual meeting from the 12th July 2016 were acknowledged by members. PR highlighted that given the number of reports circulated it was not an ideal scenario to hold a virtual meeting. MG confirmed that the decision was made on the basis that there had been a large number of apologies, and to prevent a build up of items on the September Agenda it was felt that a Virtual meeting could be held. MG did state that a virtual meeting had never been previously held for the Quality & Safety committee and therefore this would be an exception.

MG highlighted an on-going issue in relation to the collection of SMART cards, which had affected two specific areas including dermatology in relation to the choose and book system. It was highlighted that this issue would be picked up through the Clinical Reference Group to review which areas are using the choose and book system and which are not. PR raised wider concerns regarding the Choose and book system. TC stated that this had been raised at the Primary Care Commissioning Committee and it was important that the two forums linked this work together to ensure the solutions were not being taken in two different directions.

3. DECLARATIONS OF INTEREST

No declarations of interest were raised.

4. MATTERS ARISING

PR highlighted that the virtual meeting held on the 12th July 2016 had not been effective and is not in the Terms of Reference for this committee to hold a Virtual Meeting. PR stated that it would have been more beneficial to cancel or re-arrange the meeting.

5. FEEDBACK FROM ASSOCIATED FORUMS

5.1 Draft CCG Governing Body Minutes

PR highlighted that Peter McKenzie had presented a report at the last Governing Body which detailed the revision of the Policy for Declaring and Managing Interests following changes to the statutory guidance for managing such conflicts by NHS England. PR confirmed.

5.2 Health and Wellbeing Board Minutes

No minutes were available at this time.

5.3 Quality Surveillance Group Minutes

No minutes were available at this time.

5.4 Draft Primary Care Operational Management Group

The minutes were acknowledged by the committee.

5.5 Draft Clinical Commissioning Committee Minutes

RR raised an issue from the minutes regarding A&E coding that had been identified as there had been a significant shift in activity regarding categorisation. The trust was in the process of undertaking a review. MG stated that an update had been received at SMT which stated that the issue had related to Locum doctors and Junior doctors and a full review had been undertaken of the IT systems used.

PR queried which organisation would pay for complications of surgery such as infection post-surgery in contract situations such as the Nuffield? MG responded that if an acquired infection is the direct cause of the operation the Nuffield would be responsible.

5.6 Pressure Ulcer Steering Group

No minutes were available at this time.

6. ASSURANCE REPORTS

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6.1 Monthly Quality Report

NE highlighted that RWT was currently at a Level 2 concern level which may be increased to a level 3 dependent upon CQC outcome of Safeguarding concerns. MG confirmed a meeting had taken place between the Trust, the CCG and the CQC. The Trust presented its action plan at the meeting within which a number of gaps had been identified and a further meeting had been arranged for the second week in September. NE continued that the C-Diff action plan was now in place and the lead microbiologist has provided some updates to the action plan including that these occurrences are not patient to patient related but separate strands.

NE confirmed that the Never Event Action Plans are to be revisited by SISG and Quality Visits planned for September 2016 to ensure effectiveness of the actions. NE highlighted that in relation to the HSE Notification of Contravention levels there had been a revised risk assessment and action plan had been presented to the inspector on the 31st May 2016. NE confirmed that further updates would be made to CQRM.

TC highlighted an error in the report on page 8 of the report in relation to the numbers of grade 4 pressure ulcers recorded for July 2016 which is recorded at 15. NE confirmed that this is recorded incorrectly and should read in line with page 5 of the report.

NE highlighted a spike in slips trips and falls for the month of June. RR enquired as to whether the slips trips and falls e-learning package had been trialled on Ward C41 and Cardiology as these areas had been reporting high levels of slips trips and falls? MG confirmed that this was very likely the case.

NE reported that there had been a constant theme over recent months of confidentiality breaches being recorded this was attributed to user error and poor clear desk routines.

NE confirmed that there were ongoing action plans in place for both Cancer Target Compliance and A&E performance and further updates on performance would be highlighted at September's meeting.

RR stated a concern regarding complaints around 'general care' and enquired whether the trust had any strategy in place to deal with these type of issues? NE confirmed that the trust had implemented a 'human factors' training program for staff.

With regard to the BCPFT the trust were at a level 2 concern. Indeed NE confirmed that following a recent CQC inspection the trust had been rated as 'Requiring Improvement'. A further CQC visit is due to take place in the next 6 months.

NE reported a level 2 concern level against NSL (NEPTs). NE confirmed that a Contract performance Notice issued regarding performance against KPI's, a RAP is in place and being monitored on a monthly basis. It was stated that the provider would be performance managed based on providing its current performance whilst the contract is out to tender.

MG requested that the 9 care homes that fall part of the Care home framework to be highlighted in the report to enable the committee to be able to track their performance against those that are not on the framework.

It was agreed by the committee that the Engagement Assurance Framework section of the Quality report could now be removed.

NE stated that Quality Visit dates for Quarter 2 and 3 are currently being finalised and a further update could be provided at September's meeting.

6.2 Safeguarding Adults Quarterly Report

AL commenced her update by confirming that she had been confirmed into the post as Designated Adult Safeguarding Lead and was to commence in post from the 1st September 2016.

AL confirmed that the Wolverhampton Safeguarding Adults Board (WSAB) met on the 16th June 2016. It was confirmed at the WSAB that the Strategic plan had been revised to reflect accountability and outcomes. It was also noted that an editorial group was to be established to challenge the partners submissions to the WSAB Annual Assurance Report. AL confirmed that AL and MG continue to be in attendance at this meeting.

AL stated that Dawn Williams (Head of Safeguarding at Wolverhampton City Council) had presented an overview report in regard to Trafficking and Anti-Slavery activity. It was confirmed that the Wolverhampton Anti-Slavery Partnership (WASP) was a multi-agency partnership chaired by the Gang Masters Licensing Authority. It was highlighted that the over-arching aim of WASP was to identify and support victim of modern slavery in a collaborative multi-agency way.

AL highlighted that the CCG Continuing Healthcare Team are working with Mills and Reeve to ensure that the appropriate DoLs referrals to the Court of Protection are made for patients receiving CHC in their own homes. It had been agreed that the Local Authority DoLs officer will provide support for the CHC team in completing the documentation for the initial referrals.

AL confirmed that the Adult MASH is due to go 'live' on the 30th August 2016. A series of Multi Agency Briefings had been held in July 2016 which were well attended by all partner agencies.

AL reported that Wolverhampton CCG Safeguarding Team has developed a summary of DHRs recommendations and an audit tool which has been sent to Wolverhampton GP's. It was noted that Wolverhampton had been involved in 5 domestic homicide reviews in recent years.

AL confirmed that a MCA public awareness event had taken place at New Cross Hospital on the 12th May 2016 and there had also been a Dementia Awareness event in Walsall Manor Hospital on the 20th May 2016.

AL stated the draft Safeguarding Adult Review for 'RP' was presented at the safeguarding committee on Monday the 25th August 2016 were some minor amendments had been suggested.

AL confirmed that NHS England had confirmed some non-recurrent monies for Safeguarding projects for 2016/17. It was added that the CCG had been asked how they wish to utilise the resource.

6.3 Safeguarding Children and LAC Quarterly Report.

It was confirmed that this item was deferred until the September meeting.

6.4 Medicines Optimisation Quarterly Report

DB presented the Quarterly Medicines Optimisation Update, Healthcare professional have been informed about the alerts via the monthly newsletter or Script Switch information messages for February, March and April 2016.

DB highlighted to the committee the Prescribing Incentive Scheme that assists surgeries with improving their quality of prescribing. Indeed DB highlighted that this would include an Anti-biotic element to this scheme once again as in previous years. DB continued that the scheme would assist practices in optimising the use of alogliptin for the management and treatment of patients that is deemed more cost effective.

DB stated that the data from the Medicines Optimisations Dashboard may appear slightly out of date however this was as a result of the data only being available every 6 months.

6.5 Medicines Optimisation Strategy and Work Plan

DB stated that this was the CCGs first stand-alone Medicines Optimisation Strategy and Work plan which has been developed following a review by the CSU. DB reported that the strategy highlights were the CCG may be an outlier in comparison with other CCGs as well identifying possible areas for efficiency savings.

RR enquired whether any areas had been identified for de-prescribing to prevent over prescribing? DB confirmed that there would be some education working taking place in care home particularly to prevent this. It was also highlighted that patient's stock piling medication was also an issue locally and a regular review with a pharmacist would be very useful.

6.6 Quality & Risk Action Plan

NE reported that the Complaints policy had now been reviewed and was due for ratification later on the agenda. With regard to safeguarding the PREVENT policy was now awaiting ratification and implementation of the safeguarding dashboard had taken place and the first

quarter of data was now due imminently. It was noted that following the impromptu CQC safeguarding visit in July the Section 11 audit is to take place in August 2016.

NE reported that the Domestic Abuse Policy was nearing completion and was under consultation. NE stated that progress had been made on the Equality, Diversity and inclusion action plan which was highlighted in Appendix 1 of the report which was noted by the committee.

7. ITEMS FOR CONSIDERATION

7.1 Terms of Reference

The terms of reference for the committee were noted by members. It was suggested that the ToR should include a list of Core attendees and a list of attendees required on request. It was noted that this should be highlighted to Peter Mckensie.

Action: Peter Mckensie to amend Terms of Reference to reflect a Core attendance and an on-request attendance.

8. POLICIES FOR CONSIDERATION

8.1 Complaints Policy

NE confirmed that the Complaints policy had been for consultation and had been reviewed and was presented to the committee for ratification.

Policy Ratified

9. ITEMS FOR ESCALATION/FEEDBACK TO CCG GOVERNING BODY

No items were highlighted for escalation

10. ANY OTHER BUSINESS

It was confirmed that this would be the last meeting in which Geoff Ward would be in attendance as a Patient Representative. RR wished to thank Geoff for his contribution over a number of years.

11. DATE AND TIME OF NEXT MEETING

- ***Tuesday 13th September 2016, 9am – 11am, Corporate Services Boardroom, Clinical Skills Building.***

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Quality and Safety Committee
13th September 2016

Title of Report:	**Safeguarding Children (Section 11) Audit**
Report of:	WCCG Safeguarding and Looked After Children Team
Contact:	Lorraine Millard
Quality and Safety Committee Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To provide assurance that WCCG is compliant with Section 11 of the Children Act 2004 and has effective arrangements to safeguard and promote the welfare of children.
Public or Private:	Public
Relevance to CCG Priority:	
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	**Domain 1: Well led organisation** – impacting on whether the CCG: • has strong and robust leadership; • has robust governance arrangements; • involves and engages patients and the public actively; • works in partnership with others, including other CCGs; • has effective systems in place to ensure compliance with its statutory functions.

• **Domain 2a:** Performance – delivery of commitments and improved outcomes	**Performance**: delivery of commitments and improved outcomes: and ensuring standards for all aspects of quality, including safeguarding are met.
• **Domain 2b:** Quality (Improved Outcomes)	**Quality:** Also ensure that the CCG is able to demonstrate the continuous improving quality agenda for all aspects of quality including safeguarding.
• **Domain 3:** Financial Management	N/A
• **Domain 4:** Planning (Long Term and Short Term)	N/A
• **Domain 5:** Delegated Functions	N/A

1. BACKGROUND AND CURRENT SITUATION

1.1 Section 11 of the Children Act 2004 places a duty on key persons and bodies to make arrangements to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.

1.2 There are some key features off effective arrangements to safeguard and promote the welfare of children which all agencies need to take account of when undertaking their particular functions. The arrangements help agencies to create and maintain an organisational culture and ethos that reflects the importance of safeguarding and promoting the welfare of children.

1.3 The Children Act (2004) required Local Authorities to set up Local Safeguarding Children's Boards (LSCBs). One of the functions of the LSCB is to monitor the effectiveness of arrangements in a locality to safeguard and promote the welfare of children and young people. This includes monitoring compliance with Section 11 of Children Act 2004 and Section 175 of Education Act 2002.

1.4 The requirement for all agencies to safeguard and promote the welfare of children and young people is also reflected in the statutory guidance 'Working Together to Safeguard Children' 2015. This includes detailing the roles and responsibilities of respective agencies, the voluntary and private sectors and faith communities in safeguarding and promoting welfare.

2. MAIN BODY OF REPORT

2.1 Whilst Working Together 2015 specifically addresses those agencies with a statutory responsibility to safeguard and promote welfare, it also highlights that there are a number of common features that ALL organisations that provide services for children and young people or work with children and young people need to have in place at a strategic and organisational level, these key features are having;

- a clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children;
- a senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements;
- a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services;

- clear whistleblowing procedures, which reflect the principles in Sir Robert Francis's Freedom to Speak Up review and are suitably referenced in staff training and codes of conduct, and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed;
- arrangements which set out clearly the processes for sharing information, with other professionals and with the Local Safeguarding Children Board (LSCB);
- a designated professional lead
- safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check;
- appropriate supervision and support for staff, including undertaking safeguarding training:
- employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role;
- staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and procedures to be followed if anyone has any concerns about a child's safety or welfare; and
- all professionals should have regular reviews of their own practice to ensure they improve over time.
- clear policies in line with those from the LSCB for dealing with allegations against people who work with children.

2.2 The audit tool used to support this process is completed online. It contains the 11 standards with a series of sub-criteria totalling 45 across the whole audit tool. For each of the criteria, there are a set of grade descriptors ranging from 25% (red), 50% (blue), 75% (amber) to 100% (green) compliance.

2.3 Partner agencies of WSCB are required to self-assess themselves against the standards and competencies using the web-based audit tool every two years. The primary aim of this process is to assist member organisations in assessing compliance and identifying areas of further development or improvement activity.

2.4 Each agency/organisation is responsible for developing its own action/improvement plan arising from their Section 11 audit.

2.5 The WCCG self-assessment and action plan submitted on 22nd August 2016 can be found as appendix 1.

3 CLINICAL VIEW

3.1 Since January 2014 the Safeguarding Children team have maintained a self - assessment score card to assess the position of WCCG in terms of the range of safeguarding children responsibilities, with subsequent quarterly reports demonstrating where the CCG were performing well, those areas that required more attention and the results of the actions taken to ensure compliance.

3.2 The self -assessment tool developed by WCCG safeguarding team includes the standards within s.11.

3.3 A Safeguarding Audit was carried out by the Internal Audit Team in March 2016 to carry out a review of the CCG's safeguarding arrangements to ensure compliance with current legislation and guidance. A Management Action Plan has been agreed to strengthen areas where improvements can be made. The overall internal audit rating was rated as **Substantial.**

4 PATIENT AND PUBLIC VIEW

4.1 A number of standards and subsections relate to engagement with children and their families and hearing the voice of children.

5 RISKS AND IMPLICATIONS

Key Risks

5.1 Non-compliance against s.11 would result in insufficient arrangements to safeguard and promote the welfare of children, with the potential risk to children and young people and reputational risk to the organisation.

Financial and Resource Implications

5.2 N/A

Quality and Safety Implications

5.3 Commissioners are responsible for assuring themselves of the safety and effectiveness of the services they have commissioned. In order to support a clear and consistent approach to the reports provided by the services commissioned by WCCG an overarching adult and children dashboard has been included in contracts moving forward. In addition a new reporting framework has been developed – this includes the requirement to demonstrate the organisation has effective safeguarding arrangements I place and complies with s.11 of the Children Act 2004.

Equality Implications

5.3 A equality impact assessment was not required.

Medicines Management Implications

5.4 N/A

Legal and Policy Implications

5.5 Compliance is required under the Children Act 2004.

6 RECOMMENDATIONS

6.1 Recommendations

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

Name: **Lorraine Millard**
Job Title: **Designated Senior Nurse Safeguarding Children**
Date: **30.8.16**

ATTACHED: Appendix 1

Section.11 audit (competed 22.8.16)

Safeguarding
Children (Section 11)

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	**L Millard**	**30.8.16**
Public/ Patient View	**F Brennan**	**30.8.16**
Finance Implications discussed with Finance Team	**N/A**	
Quality Implications discussed with Quality and Risk Team	**Lorraine Millard**	**30.8.16**
Medicines Management Implications discussed with Medicines Management team	**N/A**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	
Information Governance implications discussed with IG Support Officer	**N/A**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	
Signed off by Report Owner (Must be completed)	**Lorraine Millard**	**30.8.16**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
COMMISSIONING COMMITTEE

Minutes of the Commissioning Committee Meeting held on Thursday 25th August 2016
Commencing at 1 pm in the Main CCG Meeting Room, Wolverhampton Science Park

MEMBERS ~

Clinical ~		**Present**
Dr J Morgans (JM)	Chair	Yes

Patient Representatives ~

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

Management ~

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

In Attendance ~

Alison Porter (AP)	CSU Contracting & Procurement	Yes
Ranjit Khular (RK)	Public Health Commissioning Officer	Yes
Liz Hull (LH)	CCG Admin Officer	Yes

Apologies for absence

Apologies were submitted on behalf of Claire Skidmore, Manjeet Garcha, Viv Griffin and Vic Middlemiss.

Declarations of Interest

CCM519 There were no declarations of interest made.

RESOLVED: That the above is noted.

Minutes

CCM520 The minutes of the last Committees, which took place on Thursday 30th June 2016 and Thursday 28th July 2016 were approved as true and accurate.

RESOLVED: That the above is noted.

Matters Arising

CCM521 (CCM508) The Value of Using Blue Teq: A discussion took place about using the system more widely in the CCG.

(CCM515) Translation Services: At the last Committee, clarification was requested in relation to a revised start date. The Committee was advised that at the Private Governing Body Meeting on 9th April 2016 the following was agreed:

- To undertake OJEU procurement for the interpreting service
- To extend the current contract, if required, should the procurement process not be completed by 31st August 2016

RESOLVED: That the above is noted.

Committee Action Points

CCM522 (CCM505) Big Lottery – Commissioning Better Outcomes: Following lack of support by the Local Authority, this project will not be pursued further. Action closed.

A discussion took place with regards to a different strategic approach to projects. It was agreed that Steven Marshall would look at pursuing this further.

(CCM504) Nuffield Health Contract: Services commissioned at the Nuffield, as per the specification, include a range of elective / planned care in the following specialties:

- General Surgery
- Ophthalmology
- Pain Management
- Musculoskeletal / Orthopaedic, including joints
- Physiotherapy

It was noted that it should be written in the contract, that as part of the discharge process, patients should go back into an NHS support pathway.

RESOLVED: That the above is noted.

Contracting & Procurement Update

CCM523 The Committee was provided with an update report relating to Month 3 (June) activity and finance performance, and includes commentary and key actions from the Clinical Quality Review and Contract Review meetings conducted in July 2016.

Royal Wolverhampton NHS Trust

Sustainability and Transformation Fund

As stated last month, the Trust has confirmed that it is formally signed up to be part of the Sustainability and Transformation Fund (STF) process. In terms of its performance requirements relating to STF, the Trust has submitted trajectories to for the following areas:

- A&E 4 hour waiting time
- 62 day cancer waiting times
- Referral to treatment incomplete pathways
- Over 6 week diagnostic waiting times

For A&E and Cancer, the trajectories are consistent with the Remedial Action Plans which are in place for those two areas. The implication to the CCG is that we cannot impose 'Double Jeopardy', which means we will not be able to enforce any contractual sanctions, withholds or impose recovery trajectories outside of the agreed STF trajectories, for these KPIs. Sanctions outside of the affected areas can still apply and the CCG is still expected to follow the GC9 process in relation to Remedial Action Plans for areas of sustained under-performance.

Highlights of Key Areas

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

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%

It has been agreed to amalgamate the Vocare UCC activity with the Trust's A&E activity and for the combined figure to be reported through Unify from August. The Trust has agreed for a separate line to be added to the Performance Dashboard so that performance of both scenarios can be monitored/ compared.

Cancer Treatment within 62 days

YTD performance as follows:

Cancer	April	May	June	July
Actual	79.88%	72.02%	81.36%	84.00%
STF Trajectory	84.00%	84.00%	85.00%	85.00%

The Trust continues to be challenged on delivery of the 62 day referral to first definitive treatment target. The predominant reasons for under-performance, from the Trust's RAP, are stated as capacity issues in Urology as well as the impact of late tertiary referrals, many of which are exceeding 42 days. There are also capacity issues highlighted in Radiology and Gynaecology services.

E- Discharge

YTD performance as follows:

E-discharge (assessment)	April	May	June	July
Actual	84.59%	87.38%	84.48%	82.94%
Target	95%	95%	95%	95%

This target continues to fail despite investment from 15/16 fines monies. E-discharge performance for ward areas also remains under target, albeit very close to achieving. The e-discharge targets are not part of STF and therefore sanctions are being applied accordingly.

Referral to Treatment within 18 weeks

YTD performance of the headline figure as follows:

RTT (headline)	April	May	June	July
Actual	84.59%	87.38%	84.48%	tbc
STF Trajectory	92%	92%	92%	94.2%

Performance Sanctions

Financial sanctions as at Month 3 (year to date total) are £71, 600.

A&E Coding Issues

The Committee was made aware of an issue with A&E activity and a potential coding and counting charge. Following an investigation by the Trust, it has been identified that the problem was caused by a system update that resulted in under-reporting of VB11Zs and over-reporting of VB09Zs. The Trust has proposed to refund the difference and details of this will be finalised by the end of August. The financial impact to the CCG is circa £60k for Quarter 1 but the rebate will apply to subsequent months until the issue is resolved.

A second A&E coding issue has been flagged to the Trust regarding potential duplicates on the system. A response to notification of this issue remains outstanding.

Other Contracts

Urgent Care Centre

Draft contracts were exchanged between Wolverhampton CCG and Vocare Limited on 5th July 2016. Having completed a face to face page turn with Vocare in late July it became clear that they had a number of issues that had not previously been raised. The CCG has now responded to all the queries, clarified the quality metrics for the contract and drafted a revised Performance Report. The final draft contract was submitted to Vocare and resubmitted it to Vocare on 12th August 2016 and is awaiting signature.

Nuffield Contract Issues/Update

It was agreed with Nuffield Health that WCCG have an individual contract rather than a joint contract in 2016/17. WCCG now lead on this contract with Cannock, Dudley, Staffs and Surrounds and South East Staffs & Seisdon Peninsular as associates.

There has been an issue with reporting of Physiotherapy data and receiving payment from the CCG. We have received all backdated information and payment agreed but will continue to monitor this going forward.

Nuffield has recently submitted a business case to the CCG for undertaking orthopaedic joint injections as outpatient procedures, which otherwise would be performed as day cases. This change is enabled through the opening of a new diagnostic suite. The business cases impacts on three HRGs and represents a small financial saving to the CCG (estimated at £3,515 per annum) as reduced outpatient tariffs apply. It is therefore more of a quality based initiative as it avoids patients having to undertake a GA if appropriate for the outpatient pathway.

The Committee approved the Business Case.

<u>Black Country Partnership Foundation Trust</u>

Non-Achievement of CQUIN Target (Quetiapine)

One of the CQUIN targets in the 2015/16 contract concerned the prescribing and monitoring of patients on Quetiapine - a drug used for patients with psychosis. An action plan has been developed however it has not yet been jointly agreed. There remain differences in interpretation of who should be undertaking the review. The Trust expects the patients to be the responsibility of primary care whereas the CCG expect that responsibility to sit with BCP psychiatrists. A meeting is being arranged to resolve this issue.

Any Other Business

CCM524 There were no items raised.

Date, Time & Venue of Next Committee Meeting

CCM525 Wednesday 28th September 2016 at **1.30pm** in the CCG Main Meeting Room.

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

Minutes of the meeting held on 30th August 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

In regular attendance:

Mr G Bahia	Business and Operations Manager
Mr V Middlemiss	Head of Contracting and Procurement
Mrs H Pidoux	Administrative Officer

1. Apologies

Apologies were submitted by Mr Oatridge and Mrs Sawrey

Mr Price took the Chair and thanked Dr Bush for his work as Chair of the Committee.

2. Declarations of Interest

FP.16.83 There was no declarations of interest.

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

FP.16.84 The minutes of the last meeting were agreed as a correct record.

4. Resolution Log

FP.16.85

- Item 88 (FP.16.76) – Update on A&E coding issues to be brought to the next meeting – included in reports on agenda and supporting paper - action closed.
- Item 89 (FP.16.76) – Update relating to BCF figures from Local Authority to be brought to the next meeting – included in Finance Report on the agenda and updates to be included in future reports – action closed.

- Item 90 (FP.16.78) – Update regarding the process and governance relating to the waiving of fines to be brought to the next meeting – clarification was given that this concerned the process followed and how sign off is agreed. Mrs Skidmore confirmed that there is a Scheme of Delegation to be followed and in this case the amount was not material therefore the CCG Executive Team has delegated authority. It was agreed that clarification would be brought to the next meet referencing the Scheme of Delegation.

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

FP.16.86 There were no matters raised.

6. Finance Report

FP.16.87 Mrs Skidmore reported on the Month 4 financial position, stating that that this is getting tighter and there is no flexibility occurring as moving through the financial year. There were 3 material variances reported in Month 4, which have a direct impact on the bottom line, as follows;

- Funded Nursing Care – Raise in prices has to be incorporated into the position. (£1.2m movement in the position).

- QIPP – it was reported that 89% of the target is expected to be met leaving approximately a£1m unallocated element. This is being considered by Programme Boards.

- Better Care Fund (BCF) - A Deep Dive exercise has taken place and the figures appear to be significantly off target. There is a mitigation plan in place; however, an addition pressure may have to be incorporated into the Month 5 figures once the information form the deep dive has been reviewed.

  It was highlighted that at the QIPP Programme Board three areas were considered to achieve further mitigation to cover the additional risk arising in the finance position. These are a review of GP referrals and the need for targeted work, contract management and future existing QIPP plans being brought forward.

  It was noted that work continues to identify schemes for 2017/18 onwards.

- RWT over activity – a confidential briefing paper was shared with the Committee setting out specific coding queries that have been lodged with the Trust and these were discussed in detail.

Resolved: The Committee;

- noted the contents of the report and the current position, particularly with regard to risk.
- Considered coding issues relating to RWT over activity.

6. Performance Report

FP.16.88 Mr Bahia highlighted that of the indicators for Month 3, 43 are green rated, 25 are red rated and 18 are unrated.

The following key points from the report were discussed;

- RTT – performance at headline level failed to achieve target. The Trust has advised industrial action by Junior Doctors continues to have an impact although all patients affected by this should have been seen by the end of June. The review of waiting list practices in Orthodontics continues to affect the performance and achievement of the target.

- A&E – challenges continue and the Trust failed to achieve the STF recovery trajectory for the month.

  From 1st August Vocare are providing daily validated figures. The triage model is being refined in conjunction with Vocare and changes introduced from July. Concerns continue regarding the use of locum consultants impacting on admission rates.

  The impact on RWT of the closure of Stafford A&E to children was raised. It was reported that this will be monitored by RWT and WMAS however the impact was considered to be minimal as paediatric cases are not generally transferred to RWT.

- 62 day Cancer Waits Tertiary Referrals – A meeting had been set up for the 8 September 2016 with Dudley CCG's Head of Quality and steps are being taken to resolve the issue.

- C.Diff – There were 2 C.Diff breaches in Month 3, which is an improvement in comparison to the numbers of breaches in previous months. Cumulatively there have been 13 breaches year-to-date, which due to the numbers of breaches in the first two months, is above the year-to-date threshold. We have seen fewer C.Diff breaches in 16/17 compared with the same period in 15/16, however there has been an increase in the number of avoidable breaches.

- RTT Waits over 52 weeks for incomplete pathways – all breaches recorded for RWT relate to orthodontic issues.

- Ambulance Handover breaches – these are above the levels in 15/16, however, the average number of conveyances have increased significantly year on year.

- E-discharge – this continues to breach although performance is above the RAP recovery trajectory.

- DToCs – performance is showing improvement due to efforts by all parties to sustain improvements through the joint discharge to assess programme that the CCG, Trust and Local Authority are running.

- IAPT measures – achieving all national KPI's for Quarter 1

The table showing performance indicators for 2016/17 was considered; Mr Price highlighted the safeguarding indicators and noted that the rating was unclear. Mr Bahia agreed that this would be reviewed and clarification given.

A discussion took place regarding this report and how to highlight what areas are important and what the CCG can influence. It was noted that work is on-going to improve the narrative in the reporting. It was agreed that at the next meeting important areas would be flagged enabling resources to be concentrated in these areas.

Resolved: The Committee

- Noted the content of the report and the updates given.
- Report to be revised for next meeting to highlight important areas for discussion.

7. Monthly Contract and Procurement Report

FP. 16.89 Mr Middlemiss highlighted that RWT performance issues were discussed earlier in the meeting. The year to date level of performance sanctions at Month 3 is £71,600; this has reduced in line with the STF requirements and the CCG being unable to enforce fines relating to STF trajectories.

As well as the A&E coding issues discussed earlier in the meeting a second issue has been identified regarding potential duplicates on the system. The CCG has not received an adequate response from the Trust and has urged that an audit is carried out as soon as possible and that the CCG is involved to develop the terms of reference and jointly evaluate the audit findings. A further response from the Trust has been requested by 2nd September.

The contract planning round for 2017/18 was raised. It was noted that initial guidance from NHS England and NHS Improvement has confirmed a requirement to complete contracting by the end of

December. This means that planning has to start earlier than normal as the timeframe has been shortened. The proposed contract principles and process were shared with the Committee and noted.

Mr Middlemiss gave an update relating to the delays in signing the contract with Vocare, the Urgent Care Centre provider. It was reported that there are 2 outstanding issues and a response on these is awaited from Vocare. A Contract Review meeting is due to be held with Vocare and if the issues are not resolved at the meeting this will then be escalated as appropriate.

Resolved – The Committee:

- noted the contents of the report

8. Any Other Business

FP.16.90 There were no items raised under any other business.

9. Date and time of next meeting

FP.16.91 Tuesday 27th September 2016 at 3.15pm, CCG Main Meeting Room

Signed:

Dated:

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE JOINT COMMISSIONING COMMITTEE

Minutes of the Primary Care Joint Commissioning Committee Meeting
Held on Tuesday 2 August 2016
Commencing at 2.00 pm in the PC108, Creative Industries Centre
Wolverhampton Science Park

MEMBERS ~

Wolverhampton CCG ~

		Present
Pat Roberts	Chair	Yes
Dr David Bush	Governing Body Member / GP	Yes
Dr Manjit Kainth	Locality Chair / GP	Yes
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	No
Gill Shelley	Senior Contract Manager (Primary Care)	Yes
Anna Nicholls	Contract Manager (Primary Care)	Yes
Charmaine Hawker	Assistant Head of Finance (Direct Commissioning)	No

Independent Patient Representatives ~

Jenny Spencer	Independent Patient Representative	No
Sarah Gaytten	Independent Patient Representative	Yes
Peter Price	Vice Chair	Yes

Non-Voting Observers ~

Ros Jervis	Service Director Public Health and Wellbeing	No
Donald McIntosh	Chief Officer – Wolverhampton Healthwatch	Yes
Dr Gurmit Mahay	Vice Chair – Wolverhampton LMC	Yes
Jeff Blankley	Chair - Wolverhampton LPC	Yes

In attendance ~

Mike Hastings	Associate Director of Operations (WCCG)	Yes
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Jane Worton	Primary Care Liaison Manager (WCCG) (Minute Taker)	Yes
Trisha Curran	Interim Accountable Officer (WCCG)	Yes
Gary Thomas	Commissioning Operations Manager (WCCG)	Yes
Claire Skidmore	Chief Finance and Operating Officer (WCCG)	Yes

Welcome and Introductions

PCC165 Ms Roberts welcomed attendees to the meeting and introductions took place. It was noted that the outstanding actions from the private session of the July 2016 Primary Care Joint Commissioning Committee would be discussed at the September meeting.

Apologies for absence

PCC166 Apologies were submitted on behalf of Alastair McIntyre, Jenny Spencer, Ros Jervis, Sarah Southall, Helen Hibbs, Laura Russell and Charmaine Hawker.

Declarations of Interest

PCC167 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 5 July 2016

PCC168 RESOLVED:

That the minutes of the previous meeting held on 5 July 2016 be approved as an accurate record subject to the following amendments:

(PCC128) NHS England Finance Update – 'Mr' Payton should be amended to 'Ms'.

(PCC129) Vertical Integration – 'Fail' should be amended to 'frail'.

Matters arising from the minutes

PCC169 RESOLVED:

That there were no matters arising to be discussed.

Committee Action Points

PCC170 **Minute Number PCC103 Protected Learning Time for GPs**
Mr Marshall stated that he would cover this action later in the agenda. Item closed.

Minute Number PCC122 NHS England Update – Primary Care Update
It was noted that this item was on the meeting agenda.

Minute Number PCC124 Wolverhampton CCG Update
It was noted that this item was on the meeting agenda.

Minute Number PCC147 NHS England Update – Primary Care Update
Ms Nicholls stated that she had confirmed that the process of adding and removing partners from practices which are involved in vertical integration remained the same as the contract is still held by the partnership and not the Royal Wolverhampton NHS Trust (RWT).

RESOLVED: That the above is noted.

NHS England Update – Primary Care Update

PCC171 In Mr McIntyre's absence, Ms Shelley presented the NHS England update to the Committee outlining the latest developments in primary medical care nationally and locally. The report included updates on the Primary Care Hub and it was noted that the next Primary Care Hub Network Meeting is scheduled for 12 August 2016 where there will be a focus on quality and Patient Participation Group (PPG) work.

A query was raised regarding what aspect of PPGs would be reviewed. It was confirmed that NHS England are undertaking work with CCGs to ensure that all PPGs are well formed as this is a contractual requirement.

With regards to GP Forward View Programmes, the Committee was informed that a Wolverhampton practice had been nominated to take part in the Vulnerable Practices Programme following discussion with the Wolverhampton Local Medical Committee.

It was noted that the annual negotiations on changes to the GP contract will be commencing shortly and that changes to the Carr-Hill formula had been expected in April but has now been suggested that it will be April 2018 instead.

The following GMS contract variations for July 2016 were stated:

Practice	Variation	Status
Bilston Health Centre & Park Street South	Removal from the contract: Dr (Mrs) Pahwa	Completed
Bilston Health Centre & Park Street South	Addition to the contract of: Dr K Ahmed, Dr V Rai, Mr Greg Moorehouse (pharmacist)	Completed

The Committee noted that although it does not impact on the GMS contract at this point in time, there are plans to change the name of Dr Pahwa's practice to IH Medical Practice.

RESOLVED: That the above is noted.

NHS England Update – Practice Participation in Enhanced Services

PCC172 Ms Nicholls presented a report to provide details of Wolverhampton practices who have signed up to deliver the following Directed Enhanced Services in 2016/17 in comparison to 2015/16. It was noted that extended hours are not included within these services. It was noted that 'Y code' (APMS) practices will already have the enhanced services wrapped into their contract and therefore it was suggested that they are recorded as 'not applicable' rather than '0' going forward.

RESOLVED: That the above is noted.

NHS England Finance Update

PCC173 In Ms Hawkers absence, Ms Skidmore provided an update and informed the Committee that NHS England are in the process of closing down the month 4 position and that there are no changes to report from month 3. It was noted that capitation data changes and non-recurrent estate programme funds will be incorporated into the month 4 report. 20:35

RESOLVED: That the above is noted.

Wolverhampton CCG Update

PCC174 Mr Hastings noted that queries had been received from Wolverhampton LMC and a response will be made within 7 days.

My Hastings gave the following update to the Committee in relation to Wolverhampton CCG primary care:

Estates and Technology Transformation Fund (ETTF) – Nationally 135 bids have been submitted of which 31 were IT related. The outcomes of all bids is currently awaited following a prioritisation process being undertaken.

Commissioning Operations Manager - Mr Hastings introduced Gary Thomas who has joined the CCG as Commissioning Operations Manager. It was noted that the current focus of the role was Wolverhampton primary care estates and a programme of work is currently being developed.

Mr Hastings provided an update on the primary care models as the CCG moves towards full delegation by 1 April 2017. A second Primary Care Home style model is being formed and there are emerging groups of practices who are looking at a 'mutual support' arrangement whereby they will look for inefficiencies and working together to share responsibilities at scale.

Wolverhampton Total Health – They are now 7 months into the preparatory 18 months as a rapid test site for the primary care home model and are liaising with health service workers and organisations to consolidate the initial ideas from the 8 practices. Patient communication has been highlighted as an issue and there is an aim to create a HUB to enable better access to services for patients.

Vertical Integration – Three practices, Lea Road Surgery, Alfred Squire Road Health Centre and MGS Medical Practice, in Wolverhampton have now successfully vertically integrated with RWT. RWT has set up a Primary Care Directorate and progress is underway to promote closer working between Primary and Secondary Care in providing a more seamless approach to patient care and communication.

Local Digital Roadmap – Plans have now been submitted and work is underway with Walsall and Dudley CCG regarding shared care records.

Capita / Primary Care Support England (PCSE) – A request has been made for all GPs to capture any specific concerns, issues or service improvements. Communications are to go out to all Practice Managers.

A query was raised about the evaluation schedule for the new models of care in Wolverhampton. It was stated that Wolverhampton Total Health is an 18 month programme of work which will be evaluated at the end of this period. The CCG is working with the RWT to develop Key Performance Indicators which will enable the CCG to monitor performance.

RESOLVED: That Mr Hastings will respond to LMC queries.

That Communications are to go out to all Practice Managers requesting PCSE feedback.

Primary Care Programme Board Update July 2016

PCC175 Ms Garcha presented an update on the delivery of the work being undertaken by the Primary Care Programme Board. A progress update on the interpreting procurement was given and no significant issues were reported.

A discussion took place around the use of Choose and Book in GP practices following a query raised by Wolverhampton Healthwatch. It was noted that the Head of Primary Care at Wolverhampton CCG was currently investigating this issue and would provide an update in due course.

A query was raised around the GP Peer Review and it was noted that Ms Garcha will present the Terms of Reference at the next Committee meeting.

RESOLVED: That Ms Garcha will present the GP Peer Review Terms of Reference at the September 2016 Committee meeting.

Primary Care Operations Management Group Update

PCC176 Mr Hastings provided an overview of the key areas covered at the Primary Care Operational Management Group Meeting which took place on 19 July 2016.

Healthwatch queried the response rate to the Friends and Family test. It was agreed that this would be reviewed at the Primary Care Operational Management Group and decide the most appropriate forum for the outcomes to be discussed. It was noted that completion of the test was a contractual requirement.

A discussion took place around prescribing issues following acute discharge and it was agreed that Mr Blankley would meet with Dee Harris, Commissioning Solutions and Development Manager – Urgent Care (Wolverhampton CCG) to review the process.

Dr Mahay stated that NHS Property Services had started to commercialise service charges for Wolverhampton GP premises. As some GPs are now receiving higher bills, it was queried whether support is being given to GPs who have received additional charges. Ms Nicholls agreed to look into this and update the Committee at the September 2016 meeting.

RESOLVED: That Mr Blankley will meet with Dee Harris to review the prescribing aspect of the acute discharge process.

That Ms Nicholls will look into support to GP practices with increased premises charges and provide an update at the September 2016 Committee Meeting.

Primary Care Forward View – WCCG Response

PCC177 Mr Marshall presented a report which outlined the new guidance which was published in April 2016 regarding general practices services for the future. The report included a summary of requirements highlighting the key areas where changes will be realised over a 5 year period as detailed within each of the chapters within the document, this included; investment, workforce, workload practice infra-structure and care redesign.

Wolverhampton Healthwatch queried whether the development of a workforce strategy would include measures designed to attract GPs to work in Wolverhampton. It was noted that the GP forward view (2016) sets out some clear parameters for GP workforce growth and Ms Garcha agreed to provide an update for the Committee at the October 2016 meeting.

RESOLVED: That Ms Garcha will bring an update on the workforce strategy, with specific reference to GP workforce growth, to the October 2016 meeting.

Any Other Business

PCC178 There were no other items raised for discussion.

RESOLVED: That the above is noted.

Date, Time & Venue of Next Committee Meeting

PCC179 Tuesday 6 September 2016 at 2.00pm in the Stephenson Room, 1st Floor, Technology Centre, Wolverhampton Science Park.

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
Primary Care Health Strategy Implementation Programme Board

Minutes of the Primary Care Health Strategy Implementation Programme Board
Held on Thursday 11 August 2016
Commencing at 1.00pm in the Brindely Room, Wolverhampton Science Park, Glaisher Drive, Wolverhampton

Present:

Sarah Southall (Chair)	Head of Primary Care, Wolverhampton CCG
Claire Skidmore	Chief Finance Operating Officer, Wolverhampton CCG
Andrea Smith	Head of Integrated Commissioning, Wolverhampton CCG
Mike Hastings	Associate Director of Operations, Wolverhampton CCG
Dr Manjit Kainth	North East Locality Chair, Wolverhampton CCG
Samina Arshad	Primary Care Lead, Wolverhampton CCG
Peter McKenzie	Corporate Operations Manager, Wolverhampton CCG
Vic Middlemiss	Head of Contracting and Procurement, Wolverhampton CCG
Laura Russell (minutes)	Primary Care PMO Administrator, Wolverhampton CCG

Apologies for absence

PCHSIPB01 Apologies were submitted on behalf of Steven Marshall, Dr Helen Hibbs/Trisha Curran, Dr Dan DeRosa and David Birch

Actions

PCHSIPB02 This was the first meeting therefore there were no actions to report.

RESOLVED: That the above was noted.

Matters Arising

PCHSIPB03 **a) Terms of Reference**

Mrs Southall presented the first draft of the Terms of Reference to the Group for their review and comments. The following comments were made:

- The membership and quoracy needed to be reviewed. It was queried whether it was appropriate for the Head of Primary Care to be Chairing the meeting as it's the Board's responsibility to hold the Head of Primary Care to account on the delivery of the Primary Care Strategy.
- It was agreed by the Board that Andrea Smith, Head of Integrated Commissioning and Sharon Sidhu Head of Strategy & Transformation are to be included on the Board's membership.
- It was important to clearly identify the governance structure for the Board including providing an oversight of the reporting structure and

the Boards level of authority in overseeing the implementation of the strategy.

- The name of Board needed to be reviewed. MH agreed to review in line with PRINCE2 methodology to duly reflect the interpretation of a programme board, to assess if this correlates with the Boards roles and responsibilities.

Mrs Southall agreed to liaise with the Executives following the meeting to finalise the terms of reference with a view of presenting a final version to the September meeting.

RESOLUTION:

Mr Hastings agreed to review the PRINCE2 methodology to assess its interpretation of a programme board and correlate this against the Boards roles and responsibilities, with a view of changing the name of the Board.

Ms Southall agreed to liaise with the Executives to finalise the Terms of Reference, and the final version to be presented to the September meeting.

Risk Register

PCHSIPB04 **a) Risk Register Report Datix**

Ms Southall shared with the Board the risk register and provided an overview of the risks pertaining to Primary Care at present.

It was agreed the Task of Finish Groups for Primary Care will manage their own risks with RED risks being escalated and monitored by the Board on a monthly basis.

Ms Arshad highlighted the Task and Finish Groups have asked if a section for escalation of risks can be included on the highlight reports in future.

RESOLUTION:

Ms Russell agreed to amend the Task and Finish Highlight Reports to include a section for risk escalation.

Performance

PCHSIPB05 **a) Implementation Plan**

Mrs Southall advised the Board the implementation plan had been development to capture the work that has commenced or due to commence. It defines the overall objectives and sub objectives including the timescales which are subject to change once the Task and Finish Groups start to develop their work streams.

Mrs Skidmore asked if the objectives could be cross referenced with the Task and Finish Groups so the Board understands the current slippage and focus on what is happening within each Task and Finish Group.

Ms Smith also noted the linkage between the Better Care Fund (BCF) and the Task and Finish Groups and queried how this work will be captured and recorded to ensure the Board are sighted on these dependencies.

Discussion took place regarding workforce as the BCF are working towards a workforce model for Community (excluded Primary Care) and the Workforce Task and Finish Group are working towards a Primary Care Workforce Strategy. The Board agreed that both strategies needed to be developed however need to underpin and link in each other.

Following discussions it was agreed that the implementation chart needed to be reviewed and amended in readiness for the next Board meeting in September. The work program would clearly define the objectives of the strategy board and the deliverables aligned to each Task and Finish Group.

RESOLUTION:
Ms Southall and Ms Russell to review the implementation plan and amend in readiness for the September meeting.

Task and Finish Group Highlight Report Including Terms of Reference

PCHSIPB06 **a) T&FG 1 – GP Contract Management**

Mr Middlemiss asked if the name of the Group could be changed to Primary Care Contract Management, the Board agreed. All to ensure any future documentation reflects this change.

Mr Middlemiss informed the Board the first meeting had taken place on 27 July 2016. The group's terms of reference was discussed and changes to the quoracy needed to be made ensuring a representative from each organisation and reference to nominated deputies are included. It was agreed future meetings are to be held 6-8 weekly and a structure chart outlining relationships and governance be included, which has now been incorporated.

The Board's aim for the Group is the oversight and development of a contract management framework for all Primary Care Services. The Group held specific discussions around the following three areas:

1. Collaborative working between NHSE, CCG and Public Health
2. Progression to fully delegated commissioning
3. Development of New Models of Care

Mr Middemiss highlighted the risk raised by the Group regarding the uncertainty of the future support from the Primary Care Hub. Mr Hastings

noted the message from NHS England is there is limited funding and the MOU is how it stands and this is going to be reviewed by April 2017.

Ms Skidmore asked how the time for GP representatives across all the Task and Finish Groups will be funded, because if this is outside their responsibilities for the CCG they will need to be paid. It was agreed following discussions all the Task and Finish Groups membership needed to be mapped to decide on the appropriateness of GP attendance across the entire Task and Finish Groups and Board.

RESOLUTION:
Ms Russell to map the attendance of all the Task and Finish Groups to review the level GP attendance required to determine cost associated with this support. Ms Southall to liaise with Ms Smith to finalise any costs as Ms Smith holds this budget.

b) T&FG 2 – Workforce Development

Ms Garcha advised that Walsall CEPN was not aligned to Walsall CCG and that all Health Education England funding goes through CEPNs, therefore there is a need to align them with Walsall CEPN. Ms Garcha has met with Walsall CCG and Dudley CCG to discuss the opportunity of having a collaborative workforce strategy. It was agreed they would take this back and discuss with appropriate colleagues. The next steps once agreed by Walsall and Dudley CCG would be to review and agree a specification and review jointly in anticipation of a STP level strategy.

Mrs Skidmore stated that Wolverhampton CCG need to be clear from the start what they need to include in the strategy to ensure Woverhampton needs are met, the viability of a collaborative approach needs consideration. Mr McKenzie highlighted that STP have cost savings associated with this area of work and would there be a risk driving the strategy in line with STP. It was agreed Ms Garcha would continue to take forward a joint approach with Walsall CCG and Dudley CCG and work towards a local specification and take forward STP discussions. However the work reflected in the strategy must be delivered locally as a priority.

The Terms of Reference for the Task and Finish Group was presented to the Group and the following was noted;

1) To remove admin from the core membership as the role is not a decision making role.
2) The need to include the Chair of the meeting under core attendees.
3) To review the role of GP as to whether they are sitting in the capacity as HEWM Primary Care Workforce Lead or as Locality Chair, as this will determine GP costings and definition/purpose of their presence.

Ms Garcha shared with the Board the consultation report prepared by Ms Navinder Dhillon on GP Workforce Planning and Development and highlighting the recommendations including any progression that has been made to date. Ms Skidmore noted from the Boards point of view they would need to see assurance the work Navinder Dhillon is undertaking is

contributing to the delivery of the primary care strategy programme of work.

The appendix of the report was shared which provided the outcomes of the consultation with GP and Practice Member staff between May to July. It highlighted the key issues and how they compared nationally. The Board noted the data provided is only relevant at this point in time, and the themes are only a majority view from the GP Practices, as not all practices have been included.

RESOLUTION: To amend terms of reference in line with strategy and the outcomes regarding funding and mapping of attendance for all Task and Finish Groups, including the workforce strategy STP foot print.

c) T&FG 3 – Developing Practice as Providers

Ms Arshad provided an overview of discussion from the meeting held on the 18 July 2016. The action from the group includes the following;

- Review of Terms and Reference
- Define and develop work programme with timescales.
- Define back office functions offer for Primary Care.
- Update Practice log to reflect visits and capture issues on an issue log.
- Map current group forming of Practices to reflect direction of travel.
- Liaison and facilitation with Practices to support forming of MCP approach.

Ms Arshad highlighted the following risks to the Board:

- Primary Care Home – work programme has been drafted it has been highlighted there is need to have commissioner provider support at a wider level in terms of prescribing. This has been raised with David Birch, Head of Medicines Optimisation who has noted at present it is only himself and Hemant Patel, Deputy Head of Medicines Optimisation who can provide this work.
- Risk Stratification – this work is already being undertaken and it is ensuring that work is embedded within this process and linking in within Nick Carey, however he leaves in November.

RESOLUTION: To amend terms of reference depending on the outcomes regarding funding and mapping of attendance for all Task and Finish Groups.

d) T&FG 4 – IM&T Business Intelligence

Mr Hastings informed the Board the IM&T have an existing programme of work which is directed nationally. The CCG have money allocated them to spend locally within this programme of work, such as;

- Supporting all the National apps
- All the clinical systems
- All support 1st, 2nd, 3rd line support helpdesk network service

- Support headquarters IT infrastructure.

This is existing programme of work which is robust, and the IM&T and Estates are enablers for all the Task and Finish Groups. Mr Hastings queried the appropriateness of reporting to the Board all IM&T deliverables and whether the specific deliverables on IM&T such as shared care records would be more beneficial for the Board. It was agreed the reporting needed to be more relevant to the Primary Care Strategy. The updates would need to include any projects up and coming relevant to the strategy and how they are progressing, being implemented, and monitoring the effectiveness. The Board agreed with this approach.

e) T&FG 5 – Clinical Pharmacists in Primary Care

Ms Arshad presented the highlight report for Clinical Pharmacists in Primary Care on behalf of David Birch, Head of Medicines Optimisation. The group met on the 21 July 2016, where it was agreed the terms of reference needed to be modified in light of earlier discussions.

It was also discussed that there is a need to provide clarity and benefits of the role of Clinical Pharmacists to GP Practices and understand which practices have recruited into his role already. The group agreed to develop a clinical pharmacist model in primary care that will encompass current existing models already in place such as Intrahealth. There is a realisation the model will be expensive for the CCG however there is work which can be carried out to make this model work efficiently.

RESOLUTION: To amend terms of reference depending on the outcomes regarding funding and mapping of attendance for all Task and Finish Groups.

f) T&FG 6 – Estates Development

Mr Hastings noted this is very similar to the IM&T Group, as Estates is an enabler, the work programme for this group is moving fast the area of work, and highlighted to the Board the work in relation to the ETTF Bids. The ETTF bids have been submitted to NHS England and a response in terms of outcomes will be received in September 2016. The highlight report also indicates work taking place outside of the ETTF bids with other funding streams. It was queried what will happen if the EFFT bids are not accepted and funding is declined, it was confirmed they the CCG will have to look at other funding streams available.

Mr Hastings advised the current terms of reference is currently being reviewed by the Group with the view to make amendments and update.

RESOLUTION: To amend terms of reference depending on the outcomes regarding funding and mapping of attendance for all Task and Finish Groups.

g) T&FG 7 – Localities as Commissioners

The meeting took place on the 18 July 2016, the group reviewed the terms of reference and amendments will be made following today's discussions. Ms Arshad noted the group discussed the pricing model for Primary Care

Services, had been approved by the Clinical Reference Group on the 13 July and endorsed by Finance and Performance Committee on the 27 July 2016. There is risk going forward for some enhance services funding will reduce.

The Board were informed that suggested service changes had been identified in the commissioning intensions process there is work in progress to address the areas requiring attention. The groups work going forward will focus on robust peer review and embedding into localities as commissioners so that they have the right tools going forward.

RESOLUTION: To amend terms of reference depending on the outcomes regarding funding and mapping of attendance for all Task and Finish Groups.

Any Other Business

PCHSIPB07 **a) Additional Guidance**

It was highlighted the Board needed to be aware of any additional guidance and how this impacts on the Primary Care Delivery. It was agreed an additional standard agenda item would be included in future to ensure this is captured.

RESOLUTION: Discussion items to be included as a standard agenda item to future meetings.

Date, Time & Venue of Next Committee Meeting

PCHSIPB08 Wednesday 7th September 2016 at 1.00pm, CCG Main Meeting Room Wolverhampton Science Park.

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY TUESDAY 11 OCTOBER 2016

Agenda item 21

Title of Report:	**Joint Negotiating Consultative Committee (JNCC)**
Report of:	Mike Hastings,
Contact:	Lisa Murray, Staff Side and UNISON representative
Governing Body Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To advise the Governing Body on discussions held at the last JNCC on 25th February, 2016
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	The CCG remains committed to maintaining a motivated and high performing workforce.
Relevance to Board Assurance Framework (BAF):	Outline which Domain(s) the report is relevant to and why – See Notes for further information
• **Domain 1:** A Well Led Organisation	A strong and motivated workforce will help the CCG to deliver against all of the BAF domains.

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

1. BACKGROUND AND CURRENT SITUATION

1.1. To update the Governing Body and provide assurance of the continued commitment of WCCG to work with staff side and staff to ensure their views are listened to and taken into consideration.

2. MAIN BODY OF REPORT

2.1. The results of the Staff Survey launched in June 2016 are currently being reviewed at the Staff Forum.
2.2. The CCG worked with UNISON on providing all staff an opportunity to attend health and well-being awareness sessions in July and August 2016. The courses were provided by the Open University, who deliver accredited courses on behalf of UNISON. These sessions were well attended and well received.
2.3. Work around the self-assessment standards tool is on-going. This Charter is an opportunity for employers to demonstrate their commitment to the health and well-being of their workforce. The Charter will provide WCCG with an easy and clear guide on how to ensure WCCG is a supportive and productive environment in which employees can flourish.
2.4. There are monthly meetings with Staff Side, HR and the Associate Director of Operations to discuss any staffing issues that may arise.
2.5. The Staff Forum's are held bi-monthly and each team within the CCG is represented.
2.6. Lisa Murray, the current Staff Side Representative, will be stepping down from her Staff Side role before the next UNISON AGM held early in 2017.

3. CLINICAL VIEW

3.1. Not applicable for this update.

4. PATIENT AND PUBLIC VIEW

4.1. Not applicable for this update.

5. RISKS AND IMPLICATIONS

Key Risks

5.1. WCCG wishes to continue developing and maintaining a strong workforce who delivers the best results for Wolverhampton. This is not possible if staff members feel demotivated and do not feel engaged with the organisation. This can manifest itself in low morale, high sickness levels and a high staff turnover. The JNCC ensures that WCCG continues to engage with and support staff.

Financial and Resource Implications

5.2. Not applicable for this update.

Quality and Safety Implications

5.3. Not applicable for this update.

Equality Implications

5.4. Not applicable for this update.

Medicines Management Implications

5.5. Not applicable for this update.

Legal and Policy Implications

5.6. Not applicable for this update.

6. RECOMMENDATIONS

6.1. To note the continued commitment of WCCG to consult with its staff and staff side representatives on any issues that impact on staff.

Name	**Lisa Murray**
Job Title	**Staff Side/UNISON Representative**
Date:	**29 September 2016**

Wolverhampton Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	**Date**
Clinical View	**N/A**	
Public/ Patient View	**N/A**	
Finance Implications discussed with Finance Team	**N/A**	
Quality Implications discussed with Quality and Risk Team	**N/A**	
Medicines Management Implications discussed with Medicines Management team	**N/A**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	
Information Governance implications discussed with IG Support Officer	**N/A**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	
Signed off by Report Owner (Must be completed)	**Claire Skidmore**	**21.12.15**