NHS
Wolverhampton
Clinical Commissioning Group

A meeting of the Wolverhampton Clinical Commissioning Group Governing Body will take place on Tuesday 13th December 2016 commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

A G E N D A

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		27	Any Other Business		
		28	Members of the Public/Press to address any questions to the Governing Body		
			Date and time of next meeting ~ Date Not Specified ~ Wolverhampton Clinical Commissioning Group Governing Body		

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
13 DECEMBER 2016

Agenda item 2

Title of Report:	**Declaration of Interest**
Report of:	CCG Chairman
Contact:	Dr Dante DeRosa
(add board/ committee) Action Required:	☒ **Decision** ☒ **Assurance**
Purpose of Report:	To advise the Governing Body of a potential Conflict of Interest for the Chairman in relation to discussions taking place between his practice and Royal Wolverhampton Trust in relation to entering into an arrangement for GP services to be sub-contracted to the Trust and for the Governing Body to discuss how this conflict will be managed.
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	Developing and Strengthening Leadership Capacity and Capability.
Relevance to Board Assurance Framework (BAF):	Outline which Domain(s) the report is relevant to and why – See Notes for further information
• **Domain 1:** A Well Led Organisation	Effective management of conflict of interests is a key element of ensuring the CCG has robust governance arrangements.

1. BACKGROUND AND CURRENT SITUATION

1.1. Royal Wolverhampton Trust (RWT) have entered into arrangements with four GP practices in the city to deliver GP services through a sub-contracting arrangement. This arrangement includes RWT employing GPs (and the other staff) working at the practice to deliver the services.

1.2. My Partners and I are currently in discussion with the Trust to enter into a similar arrangement, subject to appropriate approval through the Joint Commissioning Committee. I have recently declared this as a material change to my entry in the Register of Interests and I am now bringing this to the attention of the Governing Body.

2. MANAGEMENT OF POTENTIAL CONFLICT

2.1. As Chair of the CCG, one of my key roles is providing leadership in upholding the highest standards of integrity in line with the principles set out in our constitution and Governing Body Code of Conduct. As such, I recognise that I must set an example in proactively managing conflicts of interest that may affect my role leading the organisation. I have discussed this issue with the CCG's Conflict of Interest Guardian and agreed that the most appropriate way to manage the potential conflict that now arises is for the Governing Body to discuss the way forward.

2.2. It is clear that, as RWT is the CCG's main provider, it would not be possible for me to remain Chairman should I become an employee of the Trust. However, whilst my partners and I continue to discuss this proposal and come to a collective and personal decision on the next steps, the Governing Body need to be involved in agreeing how I will manage this conflict of interest in the meantime.

2.3. The Governing Body needs to consider whether at this stage, the potential conflict outweighs the advantages of me remaining as chair of the CCG. Should the Governing Body conclude that it is appropriate for me to remain, I am proposing that we take the following steps to manage this conflict:-

- I will continue to actively declare the conflict at the beginning of each meeting.
- With the support of the Conflict of Interest Guardian and the Corporate Operations Manager, the Governing Body will determine if my conflict of interest in any item relating to RWT means any action should take place.
- Actions which could take place could include me taking part in the discussion but stepping down from the chair for that item of business or leaving the meeting for particular items of business.
- This will apply to discussions of RWT's Finance and Quality Performance and in particular to any discussions of action to be taken by the CCG in relation to RWT's performance.

- I will not take part in discussions which relate directly to RWT's delivery of Primary Care Services or any approval or assurance process that they or the practices they are working with are conducting.

2.4 The general provisions of the CCG's Policy for declaring and managing conflicts of interest will apply to any action taken to manage this conflict of interest. In particular, this will mean that I will not receive copies of papers when the level of conflict means that this is not appropriate. The Corporate Operations Manager will be responsible for managing this process and how it applies to meetings of the Governing Body and its agendas.

3. CLINICAL VIEW

3.1. Not applicable.

4. PATIENT AND PUBLIC VIEW

4.1. Not applicable.

5. RISKS AND IMPLICATIONS

Key Risks

5.1. There is a risk that failing to maintain adequate measures for managing conflicts of interest will leave the CCG and its decision making open to challenge.

Financial and Resource Implications

5.2. There are no specific financial implications associated with this report.

Quality and Safety Implications

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

Equality Implications

5.4. There are no specific equality implications arising from this report.

Medicines Management Implications

5.5. There are no specific medicines management implications arising from this report.

Legal and Policy Implications

5.6. There are no specific legal or policy implications arising from this report.

6. RECOMMENDATIONS

That the Governing Body consider and discuss the approach outlined to managing the potential conflict of interest.

Name	**Dr Dante DeRosa**
Job Title	**Chair of CCG**
Date:	**November 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	**Peter McKenzie This report has also been discussed with Jim Oatridge, Conflict of Interest Guardian**	**16/11/16**
Signed off by Report Owner (Must be completed)	**Dr Dante DeRosa**	

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Minutes of the Governing Body Meeting held on Tuesday 8 November 2016
Commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

VOTING MEMBERS ~

Clinical ~		**Present**
Dr D De Rosa	Board Member	Yes
Dr D Bush	Board Member	Yes
Dr M Kainth	Board Member	Yes
Dr J Morgans	Board Member	No
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 Finance Officer/Chief Operating Officer	Yes
Lay Members/Consultant ~		
Mr J Oatridge	Lay Member	Yes
Mr P Price	Lay Member	Yes
Ms P Roberts ~ Chair	Lay Member	Yes
Ms H Ryan	Lay Member	Yes

In Attendance ~

Ms K Garbutt	Administrative Officer
Mr M Hastings	Associate Director of Operations
Ms J Herbert	Equality and Inclusion Business Partner
Mr R Jervis	Public Health Director
Mr P McKenzie	Corporate Operations Manager
Dr S Reehana	Interim South East Locality Chair
Ms J Watson	Price Waterhouse Cooper (Observer)

Apologies for absence

Apologies were received from Dr R Rajcholan, Dr J Morgans and Mr D Watts.

Declarations of Interest

WCCG.1614 Dr D DeRosa reported no declarations of interest.

RESOLVED: That the above is noted

Minutes

WCCG.1615 RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group Governing Body meeting held on the 11 October 2016 be approved as a correct record. However the following item was noted ~

Minute 1582 Declarations of Interest

Mr P McKenzie pointed out that there was no conflict of interest for Ms Pat Roberts regarding the End of Life Strategy.

Committee Action Points

WCCG.1616 RESOLVED: That the progress report against actions requested at previous Board meetings be noted with the following updates ~

Minute 1553 Emergency Preparedness, Resilience and Response (EPRR)

Mr M Hastings confirmed a progress report will be submitted to the Governing Body in December and a full report in February 2017.

Minute 1558 Constitution Variation

Mr P McKenzie confirmed the relevant document containing all track changes has been submitted to the Members Meeting and will be forwarded to all Governing Body Members.

Matters arising from the Minutes

WCCG.1617 There were no matters arising from the minutes.

RESOLVED: That the above is noted

Chief Officer update

WCCG.1618 Ms T Curran introduced the Chief Officer report. She pointed out 2.3 Demand Management. The Performance Team is working with the local NHS England team to develop a Demand Management Plan for referrals. There is national focus on how Clinical Commissioning Groups (CCGs) are placed to manage demand, looking at alternatives to first outpatient appointments in acute settings. Ms Curran highlighted the appendices relating to Commissioning Intentions. The documents provide an updated list of the final commissioning intentions that were published and shared with all providers on the 1 October 2016.

Ms H Ryan arrived

Ms Curran pointed out that we are currently awaiting feedback from NHS England regarding the draft Black Country Sustainability and Transformation Plan. This is planned to be published on the 21 November 2016 and there is a public engagement event planned for the 6 December 2016, this will be the first of several public events.

She added that the NHS 111 service has gone live today and confirmed an hour ago this was functioning very well; there is a 48 hour operationalisation window after which the full service will commence on the 10 November 2016.

RESOLVED: That the above is noted.

Action plan on the CCG Board Assurance Framework following the Governing Body Development session on 27 September 2016

WCCG.1619 Ms M Garcha presented agenda item 7. She highlighted the actions agreed and plan for progression. An away time to refresh the key risks will be taking place on the 22 November 2016 facilitated by Joanna Watson, who is present at today's meeting as an observer. A full action plan will be brought back to the Governing Body in January 2017.

Mr J Oatridge raised concern that the whole process seems very inward and there is no external input. The final report could include some analysis what other organisations carry out to include the private and public sectors. Ms Roberts added that a regular risk register could also be included. Ms Curran added that examples could be sourced from the internet for the Board Development Session scheduled to take place on the 22 November 2016.

Dr S Reehana arrived

RESOLVED: That an update on progress on the action plan is submitted to the Governing Body in December 2016.

That the Governing Body receive a copy of the Price Waterhouse Cooper Risk Management Review Report in January 2017.

Outcome on Pond Lane Consultation

WCCG.1620 Mr S Marshall presented the report. The Governing Body is asked to approve the proposal relating to the learning disability inpatient provision based at Pond Lane (3 beds) to alternative sites across the Black County, in Dudley, Sandwell and Walsall. He gave a brief overview of the public consultation document. He pointed out there were relatively few responses which seem to suggest there is no public view to support Pond Lane and relocate the beds. Pond Lane is still currently open, however, none of the beds are being used at present. The only component closing is the beds the site will not be closed and will be continued to use as a clinic.

Mr Marshall confirmed a full consultation had taken place. Ms Curran reminded colleagues of the finding from the Winterbourne View report and that the main focus was to ensure in the main that people were cared for outside of institutions. Ms Skidmore reported that transport could be an issue for some families; every patient has an individual care plan. Ms R Jervis indicated that public sectors have to carry out numerous consultations and sharing the learning process with the CCG would be useful.

RESOLVED: That the Governing Body agreed to relocation of three inpatient beds from Pond Lane to other sites across the Black Country, namely Orchard Hills, Penrose and Daisy Bank.

Equality Delivery System2 (EDS2)

WCCG.1621 Ms J Herbert referred to the report and apologised for the embedded documents. She highlighted the background and current situation and gave a brief overview. Ms Garcha commented in order to aid publication key members of staff have been identified and the first meeting is due to take place on 15 November 2016. Ms Curran requested that the Governing Body ask the executive team to take this forward. We need to look at the timescales and the issues need to be discussed before a decision can be made. Dr De Rosa requested that an update is given at the Governing Body in December 2016.

RESOLVED: That an update is given at the Governing Body in December 2016.

Ms J Herbert left

Primary Care Full Delegation

WCCG.1622 Mr McKenzie gave an overview of the report which is to ask that the Governing Body note the steps that will be required for the CCG to make an application for full delegation of Primary Medical Services in line with the intention set out in the Primary Care Strategy.

RESOLVED: That the Governing Body approves Wolverhampton Clinical Commissioning Groups application for full delegation responsibilities for the commissioning of primary medical services.

Commissioning Committee

WCCG.1623 Mr Marshall presented the report and highlighted that the appropriate funding will be inserted on the Children and Young People's Mental Health and Wellbeing Local Transformation Plan and this will be disseminated to the Governing Body. Ms Curran stated that this is an excellent document and thanked all staff who had carried out work on this document.

Ms Jervis pointed out that the whole system relating to looking at children's services to achieve positive outcomes and wellbeing for children in Wolverhampton requires attention. Ms Roberts added that this could be taken to the Citizens Forum in order to spread information as far as we can.

RESOLVED: That the Children and Young People's Mental Health and Wellbeing Local Transformation Plan includes the funding to be disseminated to the Governing Body.

Quality and Safety Committee

WCCG.1624 Ms Garcha presented the report and highlighted the key issues of concern within the report. She pointed out a Never Event has been reported by the Royal Wolverhampton Trust (RWT), this involves the injection of Lucentis into the wrong eye. This is the fourth Lucentis related Never Event in the last 3 years. The CCG has written to the Medical Director at RWT, a quality visit scheduled for January 2017 has been brought forward to 14 November 2016. A discussion took place regarding the number of Never Events and what we can do to prevent these. Ms Garcha will raise this with this Quality Surveillance Team as a serious issue of concern.

Ms Garcha stated that the Quality and Safety Committee meeting took place today. From this meeting an urgent care visit took place this month and this will be finalised and forwarded to RWT. Ms Jervis pointed out that there are a few teething problems at present regarding the Child Health Information System. She added that NHS England and the provider to meet with local Public Health and the CCG to discuss some of the critical issues regarding health improvement for infants and children in the city. Ms Curran pointed out that some children are missing appointments. She requested that an update is included within the Quality and Safety report. Ms Curran raised if a letter had been received relating to the Care Quality Commission (CQC) inspection around safeguarding. Ms Garcha stated this had not been received and they are being called each week regarding this.

RESOLVED: That the above is noted.

Finance and Performance Committee

WCCG.1625 Ms Skidmore tabled the Finance and Performance Committee report as there was an omission from the previous report and apologised. There are no performance material changes and the themes remain the same for A&E, cancer targets and Referral to Treatment (RTT).

Ms Skidmore added that the CCG are working very closely in connection with the RTT figures by supporting the trust to find an alternative provider if they so wish and working with practices for patients to seek an alternative route.

The financial changes to national requirements for 2016/17 are very similar and we are still on target to meet the reported position. We still face the same challenges in overspend on the Better Care Fund. There has been a slight improvement in the Quality, Innovation, Productivity and Prevention (QIPP) programme performance as at Month 6. We are still forecasting 88% of our QIPP target at month 6. Some early draft figures for 2017/18 were presented at the Finance and Performance Committee. The risks and issues were discussed and decisions to be made in the coming months. This will also be raised at the Governing Body in December.

Ms Curran stated that she had spoken to Mr David Loughton, Chief Executive at RWT, and agreed we will not go to arbitration regarding contracts.

RESOLVED: That the above is noted.

Primary Care Joint Commissioning Committee

WCCG.1626 Ms Roberts presented the report which provides the Governing Body with an update from the meeting of the Primary Care Joint Commissioning Committee on the 4 October 2016. Ms Skidmore pointed out for clarity that the interpreting procurement review of bidders is currently in progress and the new contract is subject to the Governing Body's approval at the private Governing Body meeting scheduled to take place today.

RESOLVED: That the above is noted.

Primary Care Strategy Committee

WCCG.1627 Mr Marshall gave an overview of the report which is to provide assurance on progress made towards implementation of the CCGs Primary Care Strategy. He highlighted the New Models of Care. This is a constant decision and practices will make their own decisions. The CCG are open minded and look forward to the appropriate outcomes. Mr Marshall added allowing for natural collaboration and migration through discussion and engagement. Dr De Rosa stated that we will have to amend the Governing Body constitution to reflect this.

Mr P Price asked if practices are sharing back office activities. Mr Marshall confirmed that practices are being supported in some activities.

RESOLVED: That the above is noted.

Communication and Engagement update

WCCG.1628 Ms Roberts presented the Communications and Engagement update. She highlighted the Stay Well this Winter campaign, jointly led by NHS England and Public Health Education, has formally launched throughout England with a national TV, radio, print and online advertising campaign.

Ms H Ryan stated that the IP Telephone, improving the patient experience with improved phone systems, was demonstrated at the Practice Managers Forum. Ms Roberts highlighted that it has been decided to have more interactive public engagement in 2017 by having a bus going around the city. The Patient Participation Group (PPG) meetings will now take place bi-monthly.

Dr Reehana left

RESOLVED: That the above is noted.

Minutes of the Quality and Safety Committee

WCCG.1629 RESOLVED: That the minutes are noted

Minutes of the Commissioning Committee

WCCG.1630 RESOLVED: That the minutes are noted.

Minutes of the Finance and Performance Committee

WCCG.1631 RESOLVED: That the minutes are noted.

Minutes of the Primary Care Joint Commissioning Committee

WCCG.1632 RESOLVED: That the minutes are noted.

Minutes of the Primary Care Strategy Committee

WCCG.1633 RESOLVED: That the minutes are noted

Any Other Business

WCCG.1634 There were no matters.

RESOLVED: That the above is noted.

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

WCCG.1635 **Question**

Date of Next Meeting

WCCG.1636 The Board noted that the next meeting was due to be held on **Tuesday 13 December 2016** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 3.10 pm

Chair……..

Date ……

Wolverhampton Clinical Commissioning Group Governing Body

13 December 2016

Date of meeting	Minute Number	Action	By When	By Whom	Status
12.7.16	WCCG.1520	Grant Policy Funding Allocation A report is brought back at the end of the year relating to details of the evaluation process.	February/March 2017	Vic Middlemiss	
13.9.16	WCCG.1553	Emergency Preparedness, Resilience and Response (EPRR) – A progress report is submitted to the Governing Body before Christmas and a full report in February 2017.	December 2016 February 2017	Mike Hastings	Mike Hastings confirmed a progress report will be submitted to the Governing Body in December and a full report in February 2017.
8.11.16	WCCG.1619	Action plan on the CCG Board Assurance Framework - Update on the progress of the action plan in December 2016 A copy of the Price Waterhouse Cooper Risk Management Review report is submitted to the Governing Body in January 2017	December 2016 January 2017	Manjeet Garcha	
8.11.16	WCCG.1621	Equality Delivery System2 – update to be given in December	December 2016	Manjeet Garcha	
8.11.16	WCCG.1623	Commissioning Committee – The Children and Young People's Mental Health and Wellbeing Local Transformation Plan to include funding to be distributed to the Governing Body	December 2016	Steven Marshall	

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY MEETING
13 DECEMBER 2016

Agenda item 6

Title of Report:	**Chief Officer Report**
Report of:	Trisha Curran – Interim Chief Officer
Contact:	Trisha Curran – Interim Chief Officer
Governing Body Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To update the Governing Body on matters relating to the overall running of Wolverhampton Clinical Commissioning Group.
Public or Private:	This report is intended for the public domain.
Relevance to CCG Priority:	Update by the Chief Accountable Officer.
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	This report provides assurance to the Governing Body of robust leadership across the CCG in delivery of its statutory duties. By its nature, this briefing includes matters relating to all domains contained within the BAF.
• **Domain2:** Performance – delivery of commitments and improved outcomes	
• **Domain 3:** Financial Management	
• **Domain 4:** Planning (Long Term and Short Term)	
• **Domain 5:** Delegated Functions	

1. BACKGROUND AND CURRENT SITUATION

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

2. CHIEF OFFICER REPORT

2.1 NHSE CCG Assurance Review – 'Green Star' rating

2.1.1 I am extremely pleased to report that the CCG has received a 'Green Star' rating from NHS England (NHSE) for our Quarter 1 assurance assessment. The ratings are given on four levels with green star being the highest then green, amber and red being the lowest. This means that we have maintained the equivalent of the 'Outstanding' rating that we earned last year from NHSE for the first part of 2016/17. We are thrilled that NHSE have recognised our hard work and we are continuing in our position as one of the top CCG's nationally. This is all due to the hard work, commitment and continued teamwork from each and every member of staff.

2.2 West Midlands NHS England / CCG Accountable Officers

2.2.1 A briefing and development session took place on the 22 November 2016 for West Midlands NHS England / CCG Accountable Officers. Items for discussion included the Cancer Breach Allocation Policy and Integrated working within the legal framework.

2.3 Contracts 2017/18/19 – 23 December deadline

2.3.1 The NHSE Planning Guidance issued in July 2016 set out specific requirements for NHS contracts – 'two year contract duration to support two-year local plans, with contract sign off achieved by 23 December 2016 to enable commissioners and providers greater scope for constructive engagement over contracts.'

2.3.2 The timeframe is extremely challenging requiring a coordinated, focussed approach across multiple departments within the CCG. Collectively the aim is satisfactory completion of contract negotiations within the deadline and working to ensure that arbitration is only followed as a last resort.

2.3.3 Formal contract negotiation processes have been put into place with the three main contracts which the CCG is lead commissioner for – Royal Wolverhampton NHS Trust, Black Country Partnership Foundation Trust and Nuffield Health. For all three, the process was initiated at the end of September with publication of the CCG's commissioning intentions and updated strategic roadmap. Subsequent to this and in line with planning guidance, the CCG issued contract offers to the three organisations in early November and provider responses were received a week later.

2.3.4 The current position with Royal Wolverhampton Trust is that a significant financial gap exists between the two parties (circa £17m for WCCG - excluding associate commissioners). Much of the financial gap relates to QIPP which is not recognised in the Trust offer and also very different perspectives in relation to growth/ development. It has been made clear to the Trust that the CCG will only be supporting schemes which are cost neutral and aligned to the Strategic Roadmap or can demonstrate cost savings in others areas. A sizeable challenge therefore exists over the coming weeks to close this gap as well to ensure that all of the required documentation is completed to enable sign off.

2.3.5 For Black Country Partnership Foundation Trust, the CCG is undertaking a joint negotiation process with Sandwell and West Birmingham (SWB) CCG. Whilst WCCG will be retaining its own contract, both parties are working to align key elements of the contract as much as possible, for example quality indicators, service specifications and performance management approaches. This is working well and a lot of alignment exists in these areas, whilst giving WCCG the ability to operate autonomously on specific issues, not least of all finance and activity. Currently there is a financial gap of around £1.5m between the CCG and Trust offers. Much of the gap relates to developments/ cost pressures, particularly in inpatient areas, and negotiation is on-going to close this gap.

2.3.6 2016/17 is the first year in which the CCG has been lead commissioner for Nuffield Health, so this is the second round of negotiations in that position. The initial offer to Nuffield Health has been accepted in principle however there is on-going work to finalise some key elements. The offer includes a reduction for musculoskeletal care (MSK) physiotherapy (due to the MSK procurement undertaken by the CCG), a new pathway for non-face to face pre-operative assessments and also inclusion of a small amount of activity for a new spinal service.

2.3.7 In summary, there is considerable progress being made but nonetheless a lot of work still to be done. In parallel with lead commissioner negotiations, offers are starting to come through for contracts to which the CCG is an associate commissioner. These are being closely monitored to ensure overall affordability, within the envelope of the CCG's financial plan. Contract trackers are also being submitted to NHS England on a weekly basis so that the scale of the financial gaps can be actively monitored by the centre and triangulated with provider returns.

2.4 Health Service Journal (HSJ) Awards

2.4.1 The HSJ Awards took place on the 23 November 2016 at the 02 Intercontinental Hotel and Wolverhampton CCG'S Primary Eye-care Assessment and Referral Service (PEARs) service was shortlisted as a finalist under the category of Best Adoption and Diffusion of Best Practice. The awards were attended by Claire Skidmore (Chief Finance and Operating Officer), Sharon Sidhu (Head of Strategy and Transformation), Peter Rockett (Provider Clinical Lead) and Ajay Bhatnagar (RWT Consultant Ophthalmologist). Unfortunately the CCG was competing against a number of strong contenders and lost out to Belfast Health and

Social Care Trust for Reaching Out a regional Service and network approach for upper limb treatment in cerebral palsy.

2.4.2 The PEARs service was 'highly commended' by HSJ judges.

2.5 National Diabetes Prevention Programme (DPP)

2.5.1 Wolverhampton CCG, Walsall CCG and Walsall and Wolverhampton Public Health colleagues submitted a joint expression of interest bid for the National Diabetes Prevention Programme (DPP). All partner organisations were notified on the 21 October 2016 by NHS England that we had been successful.

2.5.2 The National DPP behavioural is underpinned by three core goals; weight loss, achievement of dietary recommendations and achievement of physical activity recommendations and entails patients attending a number of sessions across a number of months. There will be a mini-procurement to identify the most suitable provider and the contract will be awarded for two years from 1 April 2016.

2.5.3 Wolverhampton CCG will be leading the DPP on behalf of partner organisations.

2.6 ETTF Update

2.6.1 The CCG made ten applications for Capital Funding from the Estates and Technology Transformation Fund at the end of June 2016. The total amount to be released nationally has reduced from £750,000 to £404,000 and has been split into three cohorts. Three Estates schemes were approved under Cohort 1 (Alfred Squire, Whitmore Reans and Dr Sharma in Bilston Health Centre) and two schemes in Cohort 2 (Parkfields Health Centre and Showell Park). Work is progressing on implementing these projects within the strict timeframes. The CCG is currently exploring options to deliver all of the remaining developments identified and will provide regular updates to the Capital Review Group of the CCG.

2.6.2 Cross organisational strategic discussions with The Royal Wolverhampton NHS Trust, Black Country Partnerships and Wolverhampton Council will be progressed via the Local Estates Forum.

2.7 Proactive Media Plan

2.7.1 A Proactive Media Strategy and Operational Plan has now been constructed for the CCG covering the entirety of the next year. This plain aims to maintain profile of the CCG building on its 'Outstanding' status and sharing its unique and innovative ideas with the public, local organisations and partners.

2.7.2 As the CCG moves to full delegation, the plan builds on the importance of securing and maintaining links with Member Practices by publicising both individual practices and the CCG together. This is being proposed to be achieved by promoting one practice per calendar month using the platform of the CCG website. During this time

they can use the platform to put out messages of best practice and patient stories. All proactive work will tie in with other broad scale communications campaigns taking place throughout the year such as the winter campaign.

2.7.3 The media plan will be presented to the Governing Body for comment and approval early next year.

2.8 Better Care Fund (BCF) Programme Board 10 November 2016

2.8.1 The meeting began with a demonstration of the Pi Care and Health Track system. This is an analytical system that pulls together Health and Social Care data. It has the potential to also capture Primary Care data. The Local Authority have procured the system initially and were seeking support to continue funding in the future as this could be a beneficial tool across the Health and Social Care system. Work needs to be undertaken to ascertain any duplication with existing systems before any commitment would be made by the CCG.

2.8.2 Work is on-going to identify scope and cost out potential estate solutions for the Community Neighbourhood Teams.

2.8.3 The Separation of the Community Intermediate Care Team (CICT) / Home Assisted Reablement Programme (HARP) team is due to commence from 21 November 2016. Staff working on this work stream have flagged a risk regarding potential gaps in service as a consequence of the separation and the situation going forward will be monitored closely.

2.8.4 Testing of the Fibonacci system is continuing and the Information Sharing Agreement is being finalised ahead of Caldicott Guardian sign off. This work along with the procurement of any IT systems will be done alongside the Local Digital Roadmap programme.

2.8.5 As directed nationally, next years' BCF Plan will be a 2 year plan in line with NHS planning guidance. The National Conditions are set to be reduced from 8 to 3, with the assurance and approval process made less cumbersome.

2.9 System Leadership and Integration – Transition Board 10 November 2016

2.9.1 There were representatives from Wolverhampton CCG, Royal Wolverhampton NHS Trust, Black Country Partnership Foundation Trust, Wolverhampton City Council were in attendance and discussion took place around new models of primary care and Local Authority new models of commissioning / delivery.

2.9.2 Colleagues also debated future estate provision to support health and care integration going forward and agreed to receive a demonstration on the Strategic Health Asset Planning and Evaluation (SHAPE) tool at the Integration Board

workshop on 15 December 2016. SHAPE[1] is a web-enabled, evidence-based application which informs and supports the strategic planning of services and physical assets across a whole health economy, which:

- Links national datasets for clinical analysis, public health, primary care and demographic data with estates performance and facilities location;
- Enables interactive investigations by Local Area Teams, Providing Trusts, CCGs, GP practices and Local Authorities;
- Supports key policy initiatives such as QIPP, JSNA, Pharmaceutical Needs Assessment and Transforming Community Services.

2.10 A&E Delivery Board

2.10.1 A meeting of the A&E Delivery Board took place on 9 November 2016. Discussion took place around winter planning, feedback on the stock take on patients considered 'medically fit for discharge' but who are awaiting on-going care packages and operational pressure escalation level (OPEL) reporting to the NHS centre.

2.11 Black Country Sustainability and Transformation Plan (STP)

2.11.1 The Black Country STP plan was published on 21 November 2016 and the CCG has put a copy on its website. The public engagement process has begun and is being managed centrally via the BC STP Communications group. Local people will be invited to have their say on the proposals through a comprehensive programme of engagement, beginning with a public event on 6 December 2016 at Bethel Convention Centre in West Bromwich. It is intended that the CCG will hold its own engagement event with people in Wolverhampton and dates are being worked up by Helen Cooke.

2.12 NHS 111

2.12.1 Care UK were successful in securing the NHS 111 / Integrated Out Of Hour (OOH) contract across the West Midlands through a competitive tendering process. There was a comprehensive mobilisation phase between the new and old providers, which concluded in a successful transition to the new service on Tuesday 8 November 2016.

2.12.2 The new integrated service will result in a seamless transition for patients between NHS 111 and the OOH providers in each area, despite having various providers in each CCG. It also includes enhanced data sharing between all providers. In addition to the core NHS 111 function, there is the introduction of a clinical hub with a multidisciplinary team consisting of a GP, Mental Health Nurse, Advanced Nurse Practitioner, Pharmacist and Dental Nurse.

[1]SHAPE is free to NHS professionals and Local Authority professionals with a role in Public Health or Social Care.

2.12.3 The first weekend of operation was a challenge for Care UK as there were staff transitioning under TUPE, new staff being appointed, training needs and increased call volume against prediction. Some elements of the performance deteriorated (calls answered in 60 seconds) during this time however Care UK utilised their wider national network to ensure the service was clinically safe. Since the initial teething issues, the service has performed at an excellent standard.

2.12.3 The clinical hub is embedding well with GPs from Primecare, Care UK and Mallins who are providing robust feedback prior to rolling it out to the remaining OOH providers.

2.12.4 Daily teleconferences are taking place to ensure continued oversight and assurance at a local level.

2.13 Winter Planning

2.13.1 The CCG has developed plans to invest Winter Planning funds from the A&E Delivery Board to assist Primary Care over the coming months. The first scheme proposed is a direct access scheme for GP appointments working in partnership with Vocare at the Urgent Care Centre at RWT. If practices are feeling the pressure of increased demand over Winter, as well as directing patients to call 111 they will have the option of allowing patients to book GP appointments at the Urgent Care Centre in normal core hours. This additional capacity will allow patients to be seen quicker and will reduce demand for urgent GP appointment in primary care. The second scheme takes on board learning from other areas, whereby there will be access to a roving GP in a car to visit patients at home on behalf of practices. This will support vulnerable patients in need of an urgent home visit and where the GP practice are unable to respond in a timely manner. This will free up capacity within GP practices and aims to not only improve response times to patients but also reduce the need to dial 999 or request an ambulance conveyance. Finally the CCG is investigating a pilot programme over the 2016/17 winter period for a shared arrangement for extended access whereby groups of practices within a Primary Care Home (PCH) will provide open GP sessions for all patients within the group. More information will be made available to practices once the projects are ready to go live.

2.14 Commissioning Support Unit (CSU)

2.14.1 Overall customer satisfaction derived from CCG staff rating support services is a 3 out of 4 (satisfied). There has been recognition of good support for Communications, Individual Funding Requests and Equality and Inclusion. Issues were raised at the Contract Meeting in respect of the recent poor support on Contracting due to staffing issues. A Remedial Action Plan has been requested and points raised have already been acted upon. There is also a focus on priority areas of work to be undertaken by the Specialist Strategic Service Improvement Team following a meeting with the CSU in October – Executive Team members with senior manager support are addressing these issues.

2.15 Demand Management

2.15.1 An area of focus from NHS England is how we are managing activity demands as a CCG. We have a demand management programme in place being led by the Strategy and Transformation team with input from across the organisation. NHSE has reviewed our plans and reported back that they are fully assured and no further iteration is required. Work is continuing on referral diversion plans with a dedicated project manager in place.

2.16 Wolverhampton Health Scrutiny Panel

2.16.1 A meeting of the Wolverhampton Health Scrutiny Panel took place on 24 November 2016. Items discussed included West Midlands Cystic Fibrosis, Vertical Integration, WCCG Mental Health Strategy 2017/19 and The 100,000 Genomes Project.

Trisha Curran
Interim Chief Officer
Date: 30 November 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**	**30/11/16**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
13 DECEMBER 2016

Agenda item 7

Title of Report:	**CCG Operating Plan 2017 -2019**
Report of:	Director of Strategy and Transformation
Contact:	Steven Marshall, Director of Strategy and Transformation
(add board/ committee) Action Required:	☒ **Decision** ☐ **Assurance**
Purpose of Report:	To ask the Governing Body to agree to sign of the CCG Operational Plan for 2017 -2019 subject to final feedback from NHS England.
Public or Private:	This Report is intended for the Public Domain
Relevance to CCG Priority:	Building Leadership Capability and Capacity
Relevance to Board Assurance Framework (BAF):	Outline which Domain(s) the report is relevant to and why – See Notes for further information
• **Domain 4:** Planning (Long Term and Short Term)	The Operational Plan has been prepared in line with national NHS Planning Guidance to fulfil the CCG's responsibilities.

1. BACKGROUND AND CURRENT SITUATION

1.1. Shared operational planning guidance for the NHS was published in September 2016. This set out that, to support the ongoing development of Sustainability and Transformation Plans (STPs), CCGs would need to develop and approve a two-year operational plan for 2017-2019 by 23 December 2016. In conjunction with this, two-year contracts with providers based on these plans would also need to be agreed by December

1.2. The CCG has been developing an Operational Plan, which consists of a narrative document and detailed financial and activity plans. A draft version was submitted to NHS England in November and feedback on the content is awaited.

2. DRAFT OPERATIONAL PLAN

2.1. The latest draft of the operational plan for 2017-2019 will be circulated at the Governing Body meeting. This is to ensure that the Governing Body have access to the most up to date version for consideration should NHS England provide detailed feedback on the initial draft and further changes be required.

2.2. The draft plan builds on the CCG's five-year strategy for the Wolverhampton health economy established in 2014, based on the vision to commission the right care, in the right place at the right time for our patient population. It sets out the work that will be undertaken to help us achieve that vision throughout the two year period.

2.3. The plan sets out our key priorities for delivery as follows:-

- Delivering our contribution to the Black Country STP;
- Supporting Greater integration of health and social care services across Wolverhampton;
- Supporting the continued improvement and development of Primary Care in Wolverhampton;
- Developing new models of care to support care closer to home and avoidable admissions to hospital;
- Meeting our statutory duties and responsibilities; and
- Supporting the development of the appropriate infrastructure for health and care across Wolverhampton.

2.4. Details of planned work to deliver against each of these priorities are set out in the plan. This includes highlighting how the CCG will deliver against the nine national 'must dos' set out in the planning guidance. It is clearly aligned with both the Black Country STP and a number of the CCGs existing strategies and plans – in particular those for Primary Care, Urgent Care and End of Life Care.

2.5. The challenges and risks facing both the CCG and our partners across the Black Country STP in delivering against these plans are acknowledged in the plan. In particular detail is given around how the CCG's operational plans will directly contribute to closing the gaps in health and wellbeing, care and quality and finance and efficiency across the STP.

3. NEXT STEPS

3.1. The Planning Guidance sets out that the Governing Body are required to approve the plans support two-year contracts being put in place by 23 December. As further amendments are likely to be required, the Governing Body are asked to consider the draft plan, make any comments and approve it as a working draft, authorising the Executive team to make the consequential amendments required following feedback from NHS England and submitting the final version on the Governing Body's behalf.

3.2. Once the final version has been submitted, the operational plan will be the driving force for the CCG's work throughout 2017-2019. The priorities set out in the plan will also be used to inform the ongoing review of risk management and Board Assurance arrangements to ensure that the Governing Body retain a clear oversight of delivery against the plan over upcoming months.

4. CLINICAL VIEW

4.1. Clinical views will be sought on the plans set out in the Operational Plan as they are developed. Governing Body members are encouraged to provide a clinical perspective on the plan during the discussion at the meeting.

5. PATIENT AND PUBLIC VIEW

5.1. The operational plan sets out a high level approach to public engagement throughout the period covered by the plan. This approach closely aligns with collaborative work both locally and across the STP footprint to ensure that engagement is targeted effectively and duplication is avoided where possible.

6. RISKS AND IMPLICATIONS

Key Risks

6.1. The Operational Plan details the high level strategic risks associated with delivery of the CCGs plan, including the financial risks involved and the level of change required to transform services and address demand in the system. More granular levels of risk will be developed through the ongoing review of arrangements to align with the delivery priorities set out in the plan.

Financial and Resource Implications

6.2. The narrative plan is accompanied by detailed financial and activity modelling that detail how plans will be delivered within the CCG's financial allocations and support the work across the STP to return the system to financial balance. Brief details of how this is aligned are included in the narrative plan.

Quality and Safety Implications

6.3. The Operational plan details both our priorities for quality improvements across the services we commission and how we will monitor and support improvements through our processes.

Equality Implications

6.4. There are no equalities implications arising from the operational plan itself as it sets out plans at a high level. Specific work in the detailed delivery plans will be subject to equality analysis as appropriate throughout their development.

Medicines Management Implications

6.5. There are specific no medicines management implications arising from this report.

Legal and Policy Implications

6.6. The Operational Plan has been drafted in line with the nationally mandated NHS Operational Planning Guidance. It meets the requirements set out in this statutory guidance.

7. RECOMMENDATIONS

That the Governing Body:-

- **Consider and comment on the working draft of the Operational Plan for 2017-2019**
- **Approve the working draft of the Operational Plan**
- **Authorise the Executive team to make the necessary amendments to the Plan and submit the final version to NHS England.**

Name Peter McKenzie
Job Title Corporate Operations Manager
Date November 2016

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	**Date**
Clinical View	To be sought on specific areas of work as required	
Public/ Patient View	To be sought in line with timescales set out in local and STP plans	
Finance Implications discussed with Finance Team	Claire Skidmore	Throughout Drafting Process
Quality Implications discussed with Quality and Risk Team	Manjeet Garcha	Throughout Drafting Process
Medicines Management Implications discussed with Medicines Management team	To be sought on specific areas of work as required	
Equality Implications discussed with CSU Equality and Inclusion Service	To be sought on specific areas of work as required	
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)	**Steven Marshall**	

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WOLVERHAMPTON CCG

Public Governing Body 13th December 2016

Agenda item 8

Title of Report:	**Authorisation of Delegation for contract signature**
Report of:	Steven Marshall
Contact:	Steven Marshall
Governing Body Action Required:	☒ **Decision** ☐ **Assurance**
Purpose of Report:	To request the GB for a delegated authorisation to sign the 17/18 & 18/19 NHS contracts
Public or Private:	This Report is intended for the public
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	The CCG has • Strong and robust leadership; • Robust governance arrangements • Has effective systems in place to ensure compliance with its statutory functions. • The CCG secures the range of skills and capabilities it requires to deliver all of its Commissioning functions, using support functions effectively, and getting the best value for money
• **Domain 2a:** Performance – delivery of commitments and improved outcomes	Demonstrates the CCGs commitments to improved outcomes and the CCG's focus on how well the CCG delivers improved services, maintains and improves quality, and ensures better outcomes for patients
• **Domain 2b:** Quality (Improved Outcomes)	Demonstrates the CCGS commitments to delivery and improved outcomes

• **Domain 3:** Financial Management	Ensures the CCG will manage its expenditure in line with its financial control targets
• **Domain 4:** Planning (Long Term and Short Term)	Demonstrates the CCGs responses to the 5YFV, the STP planning, realisation of the 5 yr. CCG strategy and the 17/18 – 18/19 Operating plan
• **Domain 5:** Delegated Functions	Demonstrates the CGG commitment to actively commission Primary Care as fully delegated organisation

1. BACKGROUND AND CURRENT SITUATION

1.1. The current planning round has been moved to a different cycle. We have been instructed by NHSE to sign a two year contract (for FYs 17/18 & 18/19) and that this take place by 23rd December at the latest. This falls between the Governing Body cycle dates and given the nature of the compressed contracting round timetable under which the CCG is operating, contract negotiations are likely to continue until the date of agreement with Providers

2. MAIN BODY OF REPORT

2.1. To request the Governing Body to authorise the Interim Accountable Officer, supported by the Chief Finance and Operating Officer and the Director of Strategy and Transformation, to sign contracts with Providers on the required date

3. CLINICAL VIEW

3.1. N/A

4. PATIENT AND PUBLIC VIEW

4.1. N/A

5. RISKS AND IMPLICATIONS

Key Risks

5.1. If the contract is not signed, the risk is one of a potential reputational damage to the CCG.

Financial and Resource Implications

5.2. The executive Directors will not countenance the signing of a contract which unduly places the CCG in financial risk and all options will be laid out and discussed in detail with the full Governing Body in a public meeting in the New Year

Quality and Safety Implications

5.3. N/A

Equality Implications

5.4. N/A

Medicines Management Implications

5.5. N/A

Legal and Policy Implications

5.6. N/A

6. RECOMMENDATIONS

The Governing Body is asked to

- To **Approve** the action requested

Name **Mr S Marshall**
Job Title **Director of Strategy and Transformation**
Date: **21 November 2016**

ATTACHED:

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body Meeting
Tuesday 13th December 2016

Agenda item 9

Title of Report:	**Emergency Preparedness, Resilience and Response (EPRR)**
Report of:	Mike Hastings, Accountable Emergency Officer
Contact:	Tally Kalea, Commissioning Operations Manager
Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	The purpose of the report is to brief the Governing Body on the EPRR status in WCCG
Public or Private:	Public
Relevance to CCG Priority:	Planning
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	The CCG is both resilient and compliant in line with statutory and regulatory requirements
• **Domain 4:** Planning (Long Term and Short Term)	The CCG has a suite of plans in place to enable it to respond to a full range of incidents, both internal and external.

1. BACKGROUND AND CURRENT SITUATION

1.1. A report was brought to Governing Body in July 2015 summarising the WCCG 2015 submission for EPRR Core Standards, subsequently agreed by NHS England as "substantially compliant".

1.2. Business continuity work within WCCG commenced however due to the CCG EPRR leads limited capacity and subsequently leaving the organisation, the CCG will need additional resource to complete the programme of work.

2. MAIN BODY OF REPORT

2.1. Each EPRR Core Standards self-assessment is comprised of a number of key standards accompanied by a "deep dive" into a particular area.

2.2. The Core Standards self-assessment is scheduled to be completed in January 2017.

2.3. The 2016/17 self-assessment "deep dive" is business continuity planning. This has been agreed with the Accountable Emergency Officer and work has already commenced but WCCG will need to acquire further resourcing to replace the previous EPRR lead. The CCG has agreed with the Local Authority to share their existing team to complete this work.

2.4. An overall work programme has been drafted in consultation with the CCGs Accountable Emergency Officer and aims to further improve both compliance and capability across the EPRR and Prevent agendas.

2.5 Work is also continuing on Pandemic Influenza. This has included developing a model for implementation across the Local Health Resilience Partnerships (LHRP) footprint. A multi-agency exercise is planned for the New Year.

2.6 Mass casualty planning is a key NHS work stream currently and is undergoing revision against latest risk and threat intelligence. WCCG is fully engaged with expectations and planning against this particular work stream. WCCG is also proactively supporting Vocare in ensuring that a seamless model for Major Incident response exists at the Wolverhampton Urgent Care Centre. These arrangements will be exercised in a "live" environment, utilising volunteers as casualties, in partnership with the Royal Wolverhampton Trust, currently planned for January 2017.

3. RISKS AND IMPLICATIONS

Key Risks

3.1. At the present time Wolverhampton CCG (WCCG) is well placed in terms of its level of preparedness and planning and continues to make progress in this area.

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

Financial and Resource Implications

3.3. The Business Continuity process will confirm the critical areas of WCCG business and ensure that such activities are able to continue, despite and throughout any disruption or incident. The identification of appropriate strategies to support business has led to a resource requirement.

Quality and Safety Implications

3.4. Based on the 2016/17 EPRR Core standards self-assessment WCCG maintains its "substantially compliant" assessment and has identified the areas for progression in the work programme presented at the September meeting. (Appendix 1)

Legal and Policy Implications

3.5. Whilst WCCG remains well placed in terms of both regulatory and statutory requirements the continued development of EPRR needs to be maintained to ensure on-going preparedness and compliance.

4. RECOMMENDATIONS

- That the Governing Body **Receive** and discuss this report

Name: **Tally Kalea**
Job Title: **Commissioning Operations Manager**
Date: **1st December 2016**

Appendix 1. 2016/17 EPRR Core Standards Self-assessment

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)	**T Kalea**	**01/12/2016**

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The EPRR Core Standards spreadsheet has 7 tabs:

Introduction - this tab,. outlining the content of the other 6 tabs and version control history

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

Business Continuity tab:- with deep dive questions to support the review of business continutiy planning for EPRR Assurance 2016-17 (blue tab) with a focus on organisational fuel use and supply.

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

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

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

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

This document is V4.0. The following changes have been made :

- Inclusion of Business Continuity questions to support the 'deep dive' for EPRR Assurance 2016-17, replacing the Pandemic Influenza tab
- Inclusion of the HART service specification for ambulance service providers and the reference to this in the EPRR Core Standards
- Inclusion of the MTFA service specification for ambulance service providers and the reference to this in the EPRR Core Standards
- Updated the requirements for primary care to more accurately reflect where they sit in the health economy
- update the requirement for acute service providers to have Chemical Exposure Assessment Kits (ChEAKs) (via PHE) to reflect that not all acute service providers have been issued these by PHE and to clarify the expectations for acute service providers in relation to supporting PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, should this be required.

	Core standard	Clarifying information	CCGs	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance								
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	• Ensuring accountaable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergeny Preparedness Resilience and Response, and Business Continuity Management agendas • Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an approporiate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.	WCCG AEO is Mike Hasting (Associate Director of Operations).		**TBC**	31.03.17
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy	Y		WCCG has an annual work program, encompassing both EPRR and BC. The work program is based around LRF, LHRP, Wolverhampton and corporate risk registers and is reviewed in light of any changes to either risk, threat, incident learning or guidance.		**TBC**	31.03.2017
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation	Y		WCCG has both EPRR and BC policies that are in line with, and reviewed against both NHS and statutory requirements. Policies are reviewed on an annual basis.		**TBC**	31.03.2017
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y		WCCG receives regular reports on EPRR through both Board and Quality & Safety Committee throughout the year. In addition the WCCG Operations Board also receives reports on an ad hoc basis.			
Duty to assess risk								
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages; • surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites) There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency as well as external risks eg. Flooding, COMAH sites etc.	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed	WCCG undertakes regular risk assessments to ensure that planning is appropriate. In addition WCCG engages with both LRF and LHRP risk registers and works through the Wolverhampton Resilienece Group to ensure common approach within the City			
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.		Y		WCCG undertakes regular risk assessments to ensure that planning is appropriate. In addition WCCG engages with both LRF and LHRP risk registers and works through the Wolverhampton Resilienece Group to ensure common approach within the City			
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	Y		Locally identified risks are considered at the Wolverhampton Resilience Group, chaired by CCG			
Duty to maintain plans – emergency plans and business continuity plans								
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.	MIRP updated			
		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Y		BC Policy updated. Corporate BIA completed with summary of MTPD for all services. Service level BIAs being commenced Aug 2016	Service level BIAs commencing Aug 2016	**TBC**	31.03.17
		HAZMAT/ CBRN - see separate checklist on tab overleaf						
		Severe Weather (heatwave, flooding, snow and cold weather)	Y		Heatwave and cold weather plans in place. Tied into BC			
		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	Y		Plan flu plan completed			
		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)						
		Mass Casualties						
		Fuel Disruption	Y		CCG unlikely to be classed as priority user under NEP- F as no delivery of direct patient care. Currently IT policy allows for home working for staff for avoidance of travel where appropriate.			
		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	Y		Surge and escalation plans in place. Tied into networks at level			
		Infectious Disease Outbreak	Y		Service specification in place. Work ongoing re meds management in absence of national guidelines			
		Evacuation	Y		Contained within building provider's plans and responsibilities			
		Lockdown						
		Utilities, IT and Telecommunications Failure	Y		Contracts/SLAs with IT and building providers around service expectations			
		Excess Deaths/ Mass Fatalities						
		having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab						
		firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab						
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • Contact details of key personnel and relevant partner agencies • Plan maintenance procedures (Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))	Y	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	MIRP, and supporting documents, all prepared in line with national guidance and against identified good practice. Plans reviewed annually as a minimum and in line with any changes to legislation, organisation or guidance.			
10	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	Y	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.	MIRP contains triggers, MI declaration info and is supported by 24/7 CCG on call rota across the BC			
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	Y		WCCG has a corporate BIA detailing recovery RTOs and preferred recovery time/% profiles.			
12	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management						
13	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		Y	• Specifiy who has been consulted on the relevant documents/ plans etc.	WCCG plans are consulted, both internally and externally, as required by each plan.			
14	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold)at the end of an incident.	Y		WCCG has a debrief policy for incidents and has a trained debriefer, both in line with national National policing College debriefing model.			
Command and Control (C2)								
15	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	WCCG has a switchboard that receives all calls during operational hours. There is a SPOC (Sandwell GH) that has Directors on call access			

	Core standard	Clarifying information	CCGs	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England publised competencies are based upon National Occupation Standards .	Y	Training is delivered at the level for which the individual is expected to operate (ie operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.	WCCG on call staff have either attended, or are scheduled to attend both SLC and EOT Training. In addition a modular training system is being developed with NHS colleagues and JESIP training is being arranged.			
17	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and scope of the organisation.	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/co0ordination centre and manage any events required.	WCCG MIRP includes action cards for all roles incl. loggist and provider liaison . In addition there s a mutual aid agreement with walsall CCG allowing relocation in the event of building loss.			
18	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.		Y		WCCG has trained loggists supported by MIRP Action card			
19	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.		Y		MIRP contains information recording and reproting templates. Process exercised during Junior Docs IA			
20	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials						
21	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident						
Duty to communicate with the public								
22	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.	WCCG has a crisis comms plan supported by CSU including a 24/7 OOH response capability. WCCG also engaged with Healthwatch to explore enhanced comms to service users in the event of an incident		

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23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.	Voice & data included in SLA with Acute Trust and covered by SLA and DR. CCG supported by duplicate, resilient data lines. Bi annual DR tests completed. Mobile comms (voice & data) embedded throughout organisation			
Information Sharing – mandatory requirements								
24	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	Y	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). • Social networking tools may be of use here.	WCCG signed up to LRF info sharing protocol. Data shared as appropriate for incidents on secure NHS mail. Based on non-statutory CCS guidance			
Co-operation								
25	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		Y	• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and memebership is quorat. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements • Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues • Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area	Representation at LRF through LHRP co chairs.			
26	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y		Representation and engagement at LRF, LHRF, LHRP WRG and others			
27	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	NB: mutual aid agreements are wider than staff and should include equipment, services and supplies.	Y		Mutual aid agreement for accomodation and EPO support via MoU with Walsall CCG			
28	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.							
29	Arrangements outline the procedure for responding to incidents which affect two or more regions.							
30	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.	Y		MIRP includes coordination role at level 3 incidents			
31	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared							
32	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months							
33	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y		AEO, or representative, attends LHRP meetings			
Training And Exercising								
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate • Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective • Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	Y	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs. • Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidentshave been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at least every three years	LHRF rep working on EPRR NOS. On call staff attended/attending SLC/EOT. EPRR training delivered on an ongoing basis. Modular EPRR training package being developed for CCG staff. Training in line with JESIP principles. Awaiting revised CCG expectations from NHS England from 2015 EPRR framework			
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. • If possible, these exercises should involve relevant interested parties. • Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	Y		Exercising program evaluated against need on an ongoing basis. Last round of training was media/crisis comms in a MI environment. Mass casualties and pandemic are the focus moving forward			
36	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		Y		WCCG staff participate fully in exercises			
37	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		Y		Strategic on call staff manual under development. Includes a CPD template for EPRR training	Document to be reviewed by peers and be ratified	Andy Smith	31.8.2016

	Core standard	Clarifying information	CCGs	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
2015 Deep Dive								
DD1	Organisation has undertaken a Business Impact Assesment	• The organisation has undertaken a risk based Business Impact Assessment of services it delivers, taking into account the resouces required against staffing, premises, information and information systems, supplies and suppliers • The organisation has identified interdependencies within its own services and with other NHS organisations and 3rd party providers • Risks identified thought the Business Impact Assessment are present on the organisations Corporate Risk Register	Y	• updated Business Imact Assessment • corporate risk register	Corporate BIA undertaken outlining corporate RTO and % service targets. Corporate BIA continues to be sanity checked against ongoing service level BIAs.	BIAs arranged at service level	**TBC**	31.03.17
DD2	Organisation has explicitly identified its Critical Functions and set Minimum Tolorable Peroiods of disruption for these	• The organisaiton has identified their Critical Functions through the Business Impact Assesment. • Maximum Tolerable Periods of Disruption have been set for all organisaional functions - including the Critical Functions	Y	• Business Continuity plan explicitly details the Critical Functions • Business Continuity plan explicitly outlines all organisations functions and the maximum torlerable period of disrution	Corporate BIA identifies MTPD for critical services	Next stage of BCMP is to draft service level plans to support corporate BIA	**TBC**	31.03.2017
DD3	There is a plan in place for the organisation to follow to maintain critical functions and restore other functions following a disruptive event.	• The organisation has an up to date plan which has been approved by its Board/Governing Body that will support staff to maintain critical functions and restore lost functions • The plan outlines roles and responsibilities for key staff and includes how a disrutive event will be communicated both internally and externally	Y	• an organisation wide Business Continuity plan that has been updated in the last 12 months and agreed the Board/Governing Body	WCCG corporate BC plan and service level plans to be reviewed and updated as work program priority during 2016/17	Next stage of BCMP is to draft service level plans to support corporate BIA	**TBC**	31.03.2017
DD4	Within the plan there are arrangements in place to manage a shortage of road fuel and heating fuel	• The plan details arrangements in place to maintain critical functions during disruption to fuel. These arrangements include both road fuel and were applicable heating fuel.	Y	• detail within the plan that explicitly makes reference to shortage of fuel and its impact of the business.	CCG unlikely to be classed as priority user under NEP- F as no delivery of direct patient care. Currently IT policy allows for home working for staff for avoidance of travel.	Will be included into individual service level plans.		
DD5	The Accountable Emergency Officers has ensured that their organisation, any providers they commission and any sub-contractors have robust business continuity planning arrangements in place which are aligned to ISO 22301 or subsequent guidance which may supersede this .	EPRR Framework 2015 requirement, page 17	Y		Model to be agreed to check a) existing providers BC; and b) incorporate BC assessment into new commissioning process	Model to embed BC as "business as usual" in commissioning to mirror work undertaken for Prevent		
DD6	Review of Critical Services Fuel Requirement Data Collection Programme (F1:F18)	Please complete the data collection below - this data set does not count towards the RAG score for the organisations. Please provide any additional information in the "Other comments" free text box.		• NHS Ambulance Trusts have already provided this information in a national collection in May 2016.				

Fuel Demand Summary

When providing information on the fuel requirements for both business as usual and to operate a critical service please ensure the supply and demand balances whereby:

Total Daily fuel use (F1) = own bunkered fuel use (F5) + any 3rd party bunkered fuel use (F6) + any forecourt fuel use (F9)

Section 1: Business as Usual Demand

F1 How much fuel do you use daily when providing a business as usual service? (litres)

Section 2: Bunkered Fuel

F2 Do you hold bunkered fuel (Yes/No)
If no go to F6

F3 What is the total bunkered fuel capacity? (litres)

F4 On average, what volume of bunkered fuel do you hold? (litres)

F5 Do you use your own bunkered fuel when providing a business as usual service?
If no go to F6

F6 Do you access a 3rd party or another service's bunkered fuel when providing a business as usual service?
If no go to F8

F7 If you have answered "Yes" to F6 or have bilateral supply agreements to operate a business as usual service, please provide a description of any agreement(s), amount of supply and companies / organisations involved.

1) What happens if I have mutual aid agreements with another Critical Service provider to utilise their bunkered stock, do I need to record the bunkered stock or will they?
DECC is requesting that the supplier records the bunkered stock holdings and the user records the demand. As the user of these bunkered fuels in this instance, please record the use of these stocks under the section referring to access to third party bunkered stock.

2) Should we assume that in the build up to an emergency our bunkered stocks would be full, as we would be prioritising deliveries and therefore the days' stock held calculations should be based on full capacity and not average daily stock holdings?
The prioritisation of supply will be dependent on the facts of any fuel shortage scenario, and will be a decision taken at the time. Data provided in the template should provide DECC with a sufficient evidence base to make decisions based on capacity and BAU bunkered stocks. Therefore please fill out the template as requested, providing notes where you think that estimates are required, or where you have had to average data in order to fit the template.

3) Our choice of bunkered fuel supplier varies depending on supply cost or availability. Who do I record as the primary supplier?
Please provide the supplier you get most of your fuel from, but also note that this varies and provide details of the other suppliers and average quantities.

4) The terminal our bunkered fuel is supplied from varies depending on who our supplier is. What should we report?
Please report your largest supplier based on average BAU, but also provide notes on any secondary service providers and average quantities obtained from those providers.

Section 3: Petrol Stations / Forecourts

F8 Do you use forecourts to operate a business as usual service? (Yes/No)
If no go to F10

F9 What is the average daily forecourt fuel use to operate a business as usual service? (litres)

Critical Service Operation Only

Please refer to question 4 of the guidance notes for further information on how to identify the fuel requirements of a critical service.
During an emergency it is expected that organisations will not be operating as normal and will only be delivering those essential services that are Critical.
Low fuel consumption alternatives should also be explored as part of the Critical Service identification process. For example, if there is the possibility that a Critical Service activity can be carried out remotely, and therefore does not require the use of fuel, this should be
The below section refers to the fuel requirements to deliver a Critical Service only.

Section 4: Critical Service Demand

F10 How much fuel would you use daily if you were providing a critical service? (litres)

Section 5: Critical Service Bunkered Fuel

F11 Do you have access to either your own or 3rd party bunkered fuel if you were providing a critical service (either from general access or mutual supply agreements)? (Yes/No)
If no go to F14

F12 What volume of your own bunkered fuel would you use daily if you were providing a critical service? (litres)

F13 What volume of 3rd party or another service bunkered fuel (either from general access or mutual supply agreements) would you use daily if you were providing a critical service? (litres)

F14 If you have answered "Yes" to F13 or have bilateral supply agreements to operate a critical service, please provide a description of any agreement(s), amount of supply and companies / organisations involved.
If no go to F15

Section 6: Critical Service Petrol Stations / Forecourts

F15 Will you need access to Designated Filling Stations (DFS) if you were providing a critical service? (Yes/No)
If no go to F17

F16 What volume of fuel would you use daily from Designated Filling Stations (DFS) if you were providing a critical service? (litres)

Critical Service Operation Only

F17 To ensure that there are adequate Designated Filling Stations* (DFS) to meet the demands of all critical users , please detail in the table below the number of vehicles required to operate a critical service
A Designated Filling Station (DFS) is a retail filling station with the purpose of only supplying road fuel for critical use only. The DFS list will be compiled to provide sites giving a good geographic coverage of the UK to meet the predicted regional demand for fuel for critical

Vehicles	Number of Vehicles required to operate a critical service
	Petrol
With NHS Logo	
Without NHS Logo	
Private vehicles	
Total	#REF!

F18 If you have answered "Yes" to question 2 (Do you hold bunkered fuel?) please detail which company primarily supplies your bunkered fuel and where known which local or regional supply depot or terminal does the fuel gets delivered from. Please select from drop down list

Who primarily supplies your bunkered fuel? Please Select from drop down list:

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	Mental Health care providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**						**Evidence of assurance**				
	Preparedness						TBC	**31.03.17**				
38	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Y	Y	Y	Y	TBC	31.03.2017				
39	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	Y	Y	Y	Y	TBC	31.03.2017				
40	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	Y	Y	Y	Y		• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)				
41	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		Y		Y							
42	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	Y	Y	Y	Y	Y	• Provision documented in plan / procedures • Staff awareness				
	Decontamination Equipment											
43	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	Y	Y	Y	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))				
44	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017	Y		Y							
45	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place	Y		Y							
46	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment		Y		Y		TBC	31.03.17				
47	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)	Y		Y							
	Training											
48	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training		Y		Y							
49	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	Y	Y	Y	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme				
50	The organisation has sufficient number of trained decontamination trainers to fully support it's staff HAZMAT/ CBRN training programme.		Y		Y							
51	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)	Y	Y	Y	Y	Y					

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

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

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations have an MTFA capability at all times within their operational service area.	• Organisations have MTFA capability to the nationally agreed safe system of work standards defined within this service specification. • Organisations have MTFA capability to the nationally agreed interoperability standard defined within this service specification. • Organisations have taken sufficient steps to ensure their MTFA capability remains complaint with the National MTFA Standard Operating Procedures during local and national deployments.			Y		TBC	31.03.17										
2	Organisations have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability.	• Deployment to the Home Office Model Response sites must be within 45 minutes.			Y		TBC	1.03.2017										
3	Organisations have the ability to ensure that ten MTFA staff are released and available to respond to scene within 10 minutes of that confirmation (with a corresponding safe system of work).	• Organisations maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA capability matrix. • Organisations ensure that, as part of the selection process, any successful MTFA application must have undergone a Physical Competence Assessment (PCA) to the nationally agreed standard. • Organisations maintain the minimum level of training competence among all operational MTFA staff as defined by the national training standards. • Organisations ensure that each operational MTFA operative is competent to deliver the MTFA capability. • Organisations ensure that comprehensive training records are maintained for each member of MTFA staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the MTFA skill sets.			Y		TBC	1.03.2017										
4	Organisations ensure that appropriate personal equipment is available and maintained in accordance with the detailed specification in MTFA SOPs (Reference C).	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable. • All MTFA equipment is maintained to nationally specified standards and must be made available in line with the national MFTA 'notice to move' standard. • All MTFA equipment is maintained according to applicable British or EN standards and in line with manufacturers' recommendations.			Y													
5	Organisations maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability.	• Organisations ensure that Control rooms are compliant with JOPs (Reference B). • With Trusts using Pathways or AMPDS, ensure that any potential MTFA incident is recognised by Trust specific arrangements.			Y													
6	Organisations have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.				Y													
7	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.				Y													
8	Organisations maintain an appropriate register of all MTFA safety critical assets.	• Assets are defined by their reference or inclusion within the National MTFA Standard Operating Procedures. • This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).			Y													
9	Organisations ensure their operational commanders are competent in the deployment and management of NHS MTFA resources at any live incident.				Y													
10	Organisations maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
11	In any event that the organisations is unable to maintain the MTFA capability to the interoperability standards, that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y		TBC	31.03.17										
12	Organisations support the nationally specified system of recording MTFA activity which will include a local procedure to ensure MTFA staff update the national system with the required information following each live deployment.				Y													
13	Organisations ensure that the availability of MTFA capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
14	Organisations maintain a set of local MTFA risk assessments which are compliment with the national MTFA risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
15	Organisations have a robust and timely process to report any lessons identified following an MTFA deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
16	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
17	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.				Y													
18	FRS organisations that have an MTFA capability the ambulance service provider must provide training to this FRS	Training to include: • Introduction and understanding of NASMed triage • Haemorrhage control • Use of dressings and tourniquets • Patient positioning • Casualty Collection Point procedures.			Y													
19	Organisations ensure that staff view the appropriate DVDs	• National Strategic Guidance - KPI 100% Gold commanders. • Specialist Ambulance Service Response to MTFA - KPI 100% MTFA commanders and teams. • Non-Specialist Ambulance Service Response to MTFA - KPI 80% of operational staff.			Y													

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations maintain a HART Incident Response Unit (IRU) capability at all times within their operational service area.	• Organiations maintain the four core HART capabilities to the nationally agreed safe system of work standards defined within this service specification. • Organiations maintain the four core HART capabilities to the nationally agreed interoperability standard defined within this service specification.			Y		TBC	31.03.17										
2	Organisaions maintain a HART Urban Search & Rescue (USAR) capability at all times within their operational service area.	• Organiations take sufficient steps to ensure their HART unit(s) remains complaint with the National HART Standard Operating Procedures during local and national deployments. • Organiations maintain the minimum level of training competence among all operational HART staff as defined by the national training standards for HART. • Organiations ensure that each operational HART operative is provided with no less than 37.5 hours protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven week period). • Organiations ensure that all HART operational personnel are Paramedics with appropriate corresponding professional registration (note s.3.4.6 of the specification). • As part of the selection process, any successful HART applicant must have passed a Physical Competence Assessment (PCA) to the nationally agreed standard and the provider must ensure that standard is maintained through an ongoing PCA process which assesses operational staff every 6 months and any staff returning to duty after a period of absence exceeding 1 month. • Organiations ensure that comprehensive training records are maintained for each member of HART staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets.			Y		TBC	1.03.2017										
3	Organisations maintain a HART Inland Water Operations (IWO) capability at all times within their operational service area.				Y		TBC	1.03.2017										
4	Organisations maintain a HART Tactical Medicine Operations (TMO) capability at all times within their operational service area.				Y													
5	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	• Four HART staff must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. Note: This standard does not apply to pre-planned operations or occasions where HART is used to support wider operations. It only applies to calls where the information received by the provider indicates the potential for one of the four HART core capabilities to be required at the scene. See also standard 13. • Organisations maintain a minimum of six competent HART staff on duty for live deployments at all times. • Once HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations can ensure that six HART staff are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. • Organisations maintain a HART service capable of placing six competent HART staff on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). Competence is denoted by the mandatory minimum training requirements identified in the HART capability matrix. • Organisations maintain any live (on-duty) HART teams under their control maintain a 30 minute 'notice to move' to respond to a mutual aid request outside of the host providers operational service area. An exception to this standard may be claimed if the live (on duty) HART team is already providing HART capabilities at an incident in region.			Y													
6	Organisations maintain a criteria or process to ensure the effective identification of incidents or patients at the point of receiving an emergency call that may benefit from the deployment of a HART capability.				Y													
7	Organisations ensure an appropriate capital and revenue depreciation scheme is maintained locally to replace nationally specified HART equipment.	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should have processes in place to use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable.			Y													
8	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.				Y													
9	Organisations ensure that the HART fleet and associated incident technology are maintained to nationally specified standards and must be made available in line with the national HART 'notice to move' standard.				Y													
10	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.				Y													
11	Organisations maintain an appropriate register of all HART safety critical assets. Such assets are defined by their reference or inclusion within the National HART Standard Operating Procedures. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).				Y		TBC	31.03.17										
12	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the HART estate specification.				Y													
13	Organisations ensure their incident commanders are competent in the deployment and management of NHS HART resources at any live incident.				Y													
14	In any event that the provider is unable to maintain the four core HART capabilities to the interoperability standards,that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
15	Organisations support the nationally specified system of recording HART activity which will include a local procedure to ensure HART staff update the national system with the required information following each live deployment.				Y													
16	Organisations maintain accurate records of their compliance with the national HART response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
17	Organisations ensure that the availability of HART capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
18	Organisations maintain a set of local HART risk assessments which compliment the national HART risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
19	Organisations have a robust and timely process to reportany lessons identified following a HART deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
20	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
21	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.				Y													

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY MEETING – PUBLIC SESSION

13 DECEMBER 2016

Agenda item 10

Title of Report:	**Black Country Sustainability and Transformation Plan – draft October 2016**
Report of:	Trisha Curran – Interim Chief Officer
Contact:	Trisha Curran – Interim Chief Officer Steven Marshall – Director of Strategy and Solutions
Governing Body Action Required:	**To agree the recommendations summarised below.**
Purpose of Report:	To provide the Governing Body (GB) with a copy of the draft Black Country STP submitted to NHSE on 21 October 2016. At its last meeting in public session the GB was given an overview of what was contained in the plan by the Director of Strategy and Solutions. At that meeting the GB was asked to agree that the plan should be submitted to NHSE on 21 October 2016 – this was agreed and confirmation of this agreement was subsequently sent to the lead Accountable Officer for the STP (AO for S&WB CCG). Organisations had been asked not to release the draft plan until feedback is received from NHSE on this latest iteration of the plan. This has now been received and is attached. The draft STP has now been shared with the public and a communications strategy is being drawn up which will be agreed by the STP Sponsorship Group consisting of AOs and CEOs of organisations across the Black Country and colleagues from the Local Authority and Healthwatch. A copy of the draft STP is on the CCG's public facing website.

	A stakeholder briefing was conducted on 3 October at the Molineux Stadium – this involved presentations on the work streams within the plan. A presentation to the public is being planned for 6 December 2016 at a Bethel Convention Centre in West Bromwich, which will include focus group sessions with the public. The CCG communications team are arranging dates for future engagement sessions with people living in Wolverhampton. Note that a paper relating to the section within the STP on commissioning is also on the agenda for this GB meeting – this paper probes further the opportunities to harmonise commissioning of some services over a wider footprint to strengthen commissioning in the future. **RECOMMENDATIONS:** The Governing Body is asked to; 1. **Receive** and **note** this report. 2. **Agree** to receive further updates as matters progress.
Public or Private:	Public session
Relevance to CCG Priority:	This document is material to all of the CCG's priorities, although nothing contained within the draft plan thus far is contrary to those priorities.
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 is material to all of the current domains within the CCG BAF.

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**	**01/12/16**

NHS
Wolverhampton
Clinical Commissioning Group

NHS Improvement
NHS England

Our ref: WM/STP/BC
Your ref:

West Midlands
213 Hagley Road
Edgbaston
Birmingham
B16 9RG

Telephone Number: 011382 51771

Sent via email

16 November 2016

Dear Andy,

Re: Black Country STP Formal Feedback

This letter provides a high level summary of our feedback from the review by NHS England, NHS Improvement, CQC, ADASS, Public Health England and Health Education England.

These points are provided to support the continued progress of your STP and the development of your public facing summary.

Appended to this letter are the current proposed next steps, actions and support that we have jointly discussed
I am aware that you will discuss this further with your sponsorship group on the 18 November and you may want to revise this in light of those discussions. If you have other suggestions as a result of these discussions for the support that you would welcome please contact your Locality Director in NHS England as soon as possible after your meeting.

Overall headline feedback

The STP has been recognised as one of the leading areas, bringing together the Health organisations in the STP and the joint focus a focused set of transformation – integration in local areas, integration across hospitals and the improvements in mental health and maternity are all well supported. You have also recognised the need to engage more with Local Authorities to truly develop the STP as a vehicle for the future for Health and Social and you have a strong foundation on which to move forward.

In your current plan, you set out clearly the triple aim and build up your STP vision based on the subsidiary structures present in the Black Country. Overall your narrative is clear and compelling although we believe it could be even stronger if the STP could be more explicit about the improvements to be delivered which will build confidence in the promised outcomes.

The STP should consider extending the 'black country provider alliance' to include all acute providers in the footprint and we will work with NHSI to support you in achieving that.

As you prepare for the "Big Conversation" with your local population and stakeholders you have recognised the need to enhance your STP Programme Leadership and develop more front and central clinical leadership.

It is important that the STP board have a shared understanding of the goals, milestones and plans of all work streams and that you are able to track progress and ensure that your work stream leads deliver on agreed priorities.

Public facing summary

Your local partnership has worked hard on your proposed engagement strategy; we all therefore want to ensure it is communicated well and in terms that the public will understand and support. NHS England has supported the work you are doing in producing a public facing document. NHS England is happy to continue to provide advice and guidance to you, to support a high quality document being available to the public. You should make the decision on when is the right time for you to publish and present this information to the local public and stakeholders

Your strategy & national alignment

Your plan has a clear vision with high level priorities; the next phase of your STP development includes public and clinical engagement and delivery of the plan. Everyone will need to focus on local engagement and the development of clear milestones. Your plan is has picked up the national strategies for urgent and emergency care, cancer and specialised services. The plan also reflects well the ambition for 7 day services and spread of new care models
We would however encourage clearer work on these areas in the acute services review, and on creating a fuller model for acute care that aligns with the vision and pathways in each new local system. It would be useful to provide clarity on any proposed capacity changes to the acute care sector. Your STP includes significant capital investment for the MMH development. It is important that the STP resolves the commissioning and financial strategy underpinning this development and aligns the income, activity and clinical model based on this work.
The ambition for Mental Health needs to develop proposals on children and young people's mental health, which is not mentioned, and you could improve the plan by providing clarity on how you will use finances in this area.
Maternity plans need attention to provide confidence and assurance that the STP as a whole can deliver in this area.

Delivering the Triple Aim

As you move now into delivering your STP, please do ensure that all your organisations continue to work jointly together, to focus on ensuring you are all clear that the work you must now progress, delivers improved wellbeing, transforms the quality of care and operates within the financial resources you have available in the system.

The planning process for the next 2 years provides a good opportunity for the system to jointly focus on short term goals and plan for the longer term.

NHS England will continue our regular dialogue and support programme with your STP as we support you now move from planning to engagement and delivery. If you are any

questions or would like more detailed feedback on your plan, please do contact your Locality Director in the first instance.

Next steps

All STPs will be formally reviewed on the 16 November by NHS England and NHS Improvement nationally. Black Country has been identified as a plan that we have confidence in with further work and support. Any further feedback from this national review will be provided in due course, but we are not anticipating this.

NHS England and NHS Improvement will seek to enhance our dialogue and support programme with your STP as we support you to now move from planning to engagement and delivery. If you have any questions or would like more detailed feedback on your plan, please do contact your Locality Director in the first instance.

Yours sincerely

Alison Tonge
Director of Commissioning Operations
NHS England - West Midlands

Fran Steele
Delivery and Improvement Director
NHS Improvement

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NHS
Wolverhampton
Clinical Commissioning Group

NHS Improvement

NHS England

[DRAFT] BC STP support action plan

Footprint Actions

What are the footprints doing to prepare for and resource implementation?

Timeline to be confirmed

1. Refine planning assumptions based on revised control totals
2. Scale up clinical, stakeholder and public engagement particularly Local Authority
3. Consider aligning existing transformation resources to STP priorities
4. Increase central PMO team resource

In the next six months: (Feb-Apr)

1. Undertake refinement of solutions following further analytical modelling
2. Fully implement revised governance structure for delivery
3. Begin implementation for 2017/18 schemes

In the next twelve months: (May-Sept)

1. Deliver MCP contracts in shadow form

Region Actions

What will the regional team do to support STPs prepare for implementation?

Timeline to be confirmed:

1. Governance/OD
2. Facilitating discussions (Specialised and NHSE)
3. Capital
4. Boundaries
5. Network clinical solutions

Proposed National Actions

What should the national team do to support implementation?

Timeline to be confirmed:

1. Find out how the STF is used to modernise functions and the release of STF money

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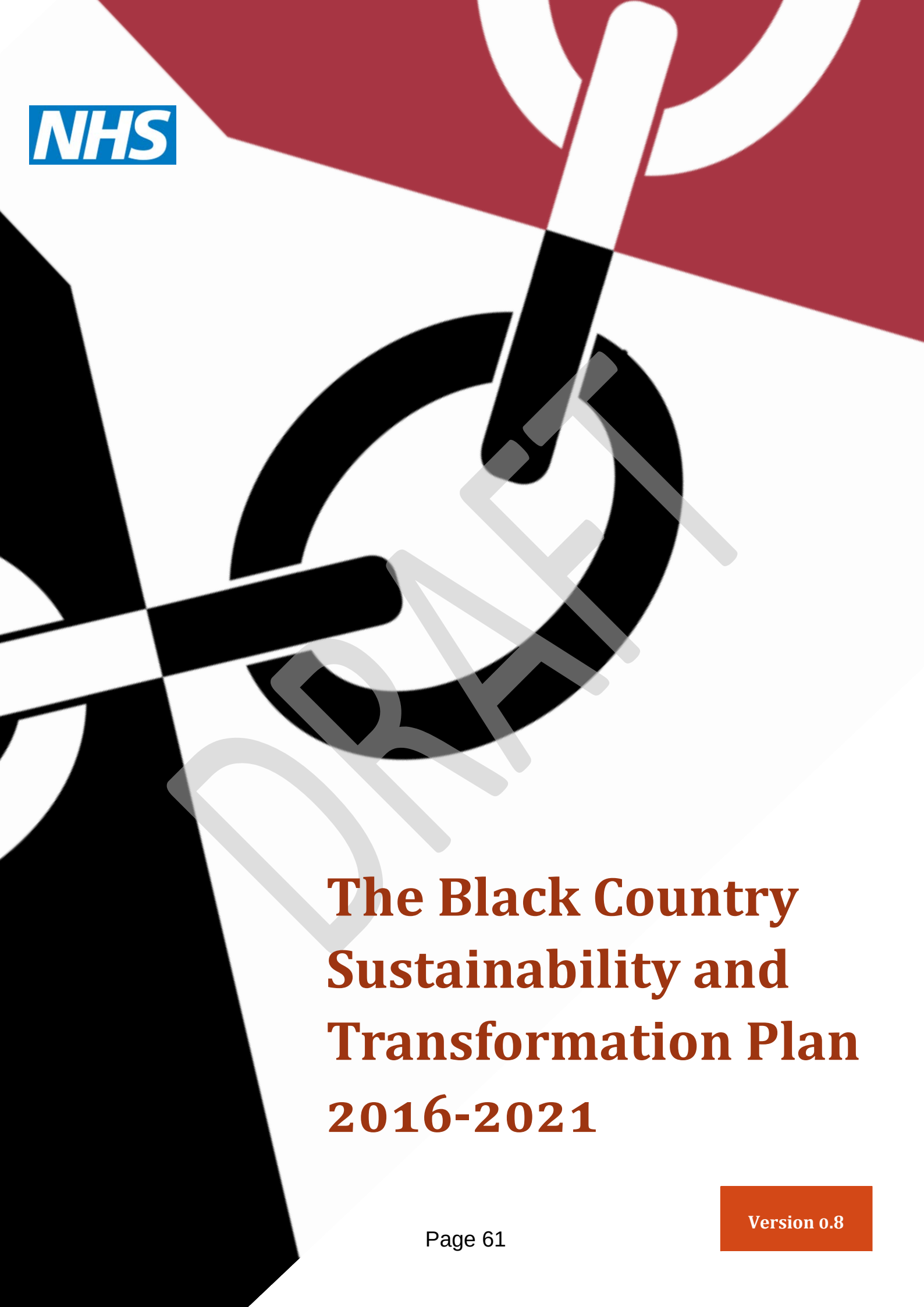


The Black Country Sustainability and Transformation Plan 2016-2021

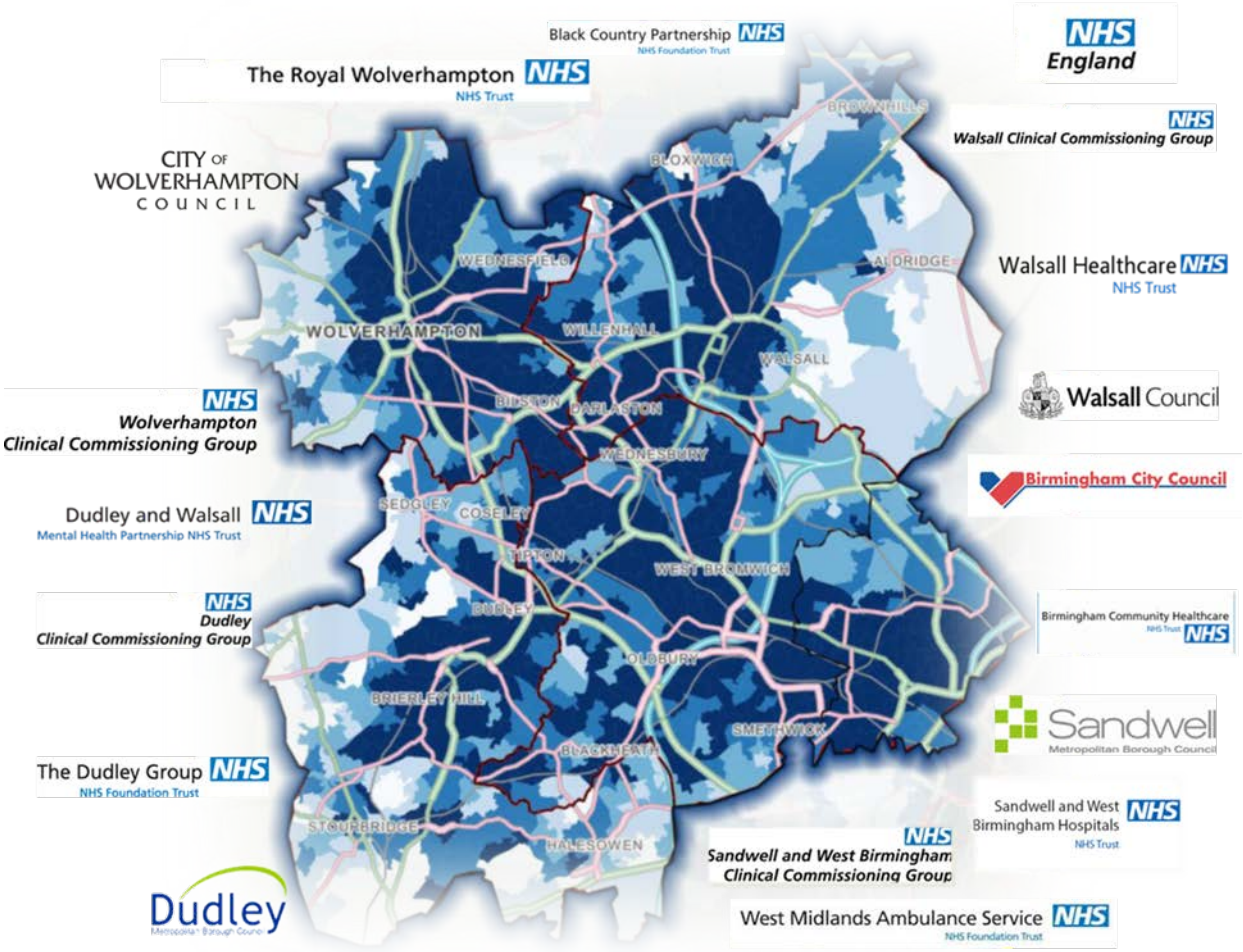
Version 0.8

Version Control

Date	Version	Notes
15 August 2016	V0.1	Initial draft compiled from June STP submission, workstream updates and subsequent NHSI submissions
24 August 2016	V0.2	Update following review by Sponsoring Group
25 August 2016	V0.3	Annotated with further detail required from workstreams by 5th Sept
14 September 2016	V0.4	Further detail from VI, HI and Maternity workstreams
19 September 2016	V0.5	Revised financial narrative following 16 Sept template submission and input from specialized commissioners, plus changes from review by Sponsoring Group.
03/10/2016	V0.6	Further detail from VI workstream plus Mental Health and Economic impact studies
12/10/2016	V0.7	Full revision following review by Transformation Groups and Workstreams.
20/10/2016	V0.8	Changes as agreed following review by Sponsoring Group and to align with latest financial analysis.

The Black Country and West Birmingham

In order to develop this transformational plan for our local health and care system, eighteen local partner organizations have committed to a unique degree of collaborative working for the benefit of the Black Country and West Birmingham's 1.4 million population – 46% of whom live in the most deprived areas of England.



Some key principles shape our collaboration:

Subsidiarity

We serve five distinct local communities – Birmingham (West), Dudley, Sandwell, Walsall and Wolverhampton – each with their own unique histories, strengths and challenges. We will ensure that our collaboration does not undermine the existing excellence and innovation in each area. There is a very strong sense of place across Black Country and West Birmingham.

Collective Added Value

We believe that, through working together, we can build on our strengths, achieving a scale and pace of transformation that we cannot realise in isolation. In financial

terms, the added value to be delivered through coordinated action at STP level by NHS organisations is £413m (allowing for an additional £99m national funding). This is approximately £178m more than our NHS organisations would be expected to achieve without the STP.

Our partnership work has been advancing ahead of the formation of the STP through bodies such as the West Midlands Combined Authority, the Black Country Alliance and the Transforming Care Together partnership. Through the STP, we can now ensure that initiatives already being undertaken within Black Country and West Birmingham organisations are used to their greatest effect.

In addition:

- We have determined not to duplicate any processes or structures through our collaborative working; and
- Our functioning as an STP will not limit the way in which we liaise with neighbouring areas for patient benefit.

Contents

Preface

This draft plan sets out an ambitious approach to transforming our local health and care system in the Black Country and West Birmingham.

Our aim is to materially improve the health, wellbeing and prosperity of the population through providing standardised, streamlined and more efficient services.

The STP's Sponsoring Group, formed of the leaders of eighteen local health and social care organisations, has prepared this draft plan to enable wider engagement. It proposes a number of critical recommendations:

- To implement **LOCAL PLACE-BASED MODELS OF CARE** for each community that deliver improved access to local services for the whole population, greater continuity of care for those with ongoing conditions and more coordinated care for those with the most complex needs. This work will build on the Multispecialty Community Provider (MCP) and Primary and Acute Care Systems (PACS) approaches which are already being developed with local communities, in order to deliver an 'Accountable Care Organisation'[1] model appropriate to each of our localities;

- To create, through **EXTENDED COLLABORATION BETWEEN SERVICE PROVIDERS**, a coordinated system of care across the Black Country and West Birmingham to improve quality and to deliver efficiencies on a scale not accessible to individual organizations. This will build on existing collaborations such as the Black Country Alliance and the Transforming Care Together Partnership for **MENTAL HEALTH AND LEARNING DISABILITY SERVICES**, and it includes the development of the new Midland Metropolitan Hospital (bringing together acute services from Sandwell and City hospitals) following Public Consultation in 2007;

- To take coordinated action to address the particular challenges faced by our population in terms of **MATERNAL AND INFANT HEALTH**, and to create a single Black Country and West Birmingham maternity plan that inter-relates with Birmingham and Solihull where necessary;

- To work together on **KEY ENABLERS** that will enable us to achieve significant workforce efficiency and transformation, to deliver the digital infrastructure required for modern patient-centred services, to rationalise public sector estate utilisation, and to streamline commissioning functions; and

- To act together, and in partnership with the West Midlands Combined Authority, to address the **WIDER DETERMINANTS OF HEALTH** such as employment, education and housing.

This document summarises how we can build on existing strengths, accelerating our learning from innovation, to create a sustainable health system with improved health outcomes and a better patient experience of services.

[1] http://www.kingsfund.org.uk/topics/integrated-care/accountable-care-organisations-explained

How our plan could benefit people in the Black Country and West Birmingham:

- With an extra £25m invested in GP services by 2021, an extra 25,000 primary care appointments a year will be made available. All children under 5 and adults over 75 will be guaranteed same day access to GP appointments, meaning 200,000 people will be able to see a family doctor when they need to.
- Over 1,000 people a month who turn up at A&E will be able to have their problem assessed and treated by a GP, reducing waits and improving care.
- Across the Black Country and West Birmingham, there will be at least 40,000 additional home visits, clinics and appointments offered in local surgeries and health centres, as close to home as possible.
- From November 2016, by ringing one telephone number the 1.4m people who live in the Black Country will be able to book a doctor's appointment, in the evening and at the weekend, get dental advice, order a repeat prescription, or get urgent advice.
- By 2021, over 100,000 people will be saved a trip to hospital for their outpatient care, with more treatment offered in local GP surgeries and health centres.
- By bringing all cancer services up to the standard of the best, cancer one year survival rates will reach over 70 per cent in the Black Country and West Birmingham.
- Common sense changes to the way our family doctors, hospitals and care services work together will reduce the number of people visiting A&E by 3,000 a week by 2021, meaning faster treatment and care for the most seriously ill.
- By 2021, instead of having to be admitted as an emergency to hospital, an extra 1,000 people each week will be cared for in their own home or local community by doctors, nurses and paramedics.
- Around 34,500 patients with long term conditions, such as diabetes or heart problems, will be given technology to monitor their heart rate and bloody pressure remotely, alerting the doctor if there are any signs of deterioration so problems can be nipped in the bud early.
- Local clinical teams involving GPs, community nurses, mental health services and social care will provide better coordinated care for our most vulnerable patients with very complex needs.
- The new Midland Metropolitan Hospital will bring hospital services in Sandwell and West Birmingham together in one place to treat over 570,000 people in a state of the art building.
- By using our specialist NHS staff in a different way, patients who suffer major trauma, stroke, heart attack, or those who have cancer, kidney failure or breathing problems will receive the best treatment and care.
- Changes to how health and care services work together will mean those suffering early psychosis will get access to therapy within two weeks.
- The NHS in the Black Country and West Birmingham will reduce current high levels of infant mortality to bring it in line with the national average, avoiding the death of 34 babies a year - the equivalent of one child every eleven days.
- By tackling waste, improving standards and working together, we can avoid a potential increase in health costs of over £413 million per year by 2021. This will give better value to the taxpayer, equivalent to £680 a year for every household in the Black Country and West Birmingham.

Executive Summary

This document outlines our draft plans for transforming health and care services across the Black Country and West Birmingham. It is a 'work in progress' and we are now looking to engage and communicate effectively with our patients, public, partners, staff and stakeholders across the Black Country and West Birmingham in order to develop our plans further and to agree how to implement them in the best possible way.

The demands on health and care resources are rising year on year – people are living longer with ever more complex conditions; continuing progress in treatments and medical techniques comes with new costs and expectations; and modern lifestyle issues such as obesity are causing an increase in long term conditions. For the future, we must transform services to adapt to these rising demands. We must make the most of modern healthcare through innovation and best practice in order to change the way we spend money and use our limited resources. We must also focus on shifting demand away from our hospitals and to a more community-centred approach. When patients need hospital care, however, it should be of the highest quality, providing specialist interventions in the right place and at the right time with less variation in the care that patients receive.

Our vision is to transform health and care in the Black Country and West Birmingham. We need to bridge three critical gaps:

- **Our populations suffer significant deprivation, resulting in poor health and wellbeing;**
- **The quality of the care we offer varies unnecessarily from place to place, so not everyone has the best experience of care or the best possible outcome; and**
- **We risk not being able to afford all the services our populations need unless we take early action to avoid future costs, creating a sustainable health and care system that helps Black Country and West Birmingham lives to thrive.**

It is clear to us that our current ways of operating are unsustainable. Under our plan, individual organisations and partnerships will continue to make the improvements and efficiencies that are directly within their own control but the overall scale of opportunity will be transformed by our working together as a single system with a common interest.

At the heart of our plan is a focus on standardising service delivery and outcomes, reducing variation through place-based models of care provided closer to home and through extended collaboration between hospitals and other organisations. Mental Health and Learning Disabilities services form part of this but are also identified as a discrete strand to reinforce parity of esteem, the necessity of which is confirmed by a study we commissioned that shows the much reduced life expectancy of mental health service users. Maternity and Infant Health is also an essential focus for us given our challenges around maternal health (in particular, maternal smoking) and its impact on neonatal death rates and other infant

outcomes. Maternity and neonatal service capacity also needs to be reviewed.

In addition to the challenges we face in terms of health and wellbeing outcomes and of variations in the quality of care, the local NHS is estimated to face a £512m financial gap by 2020/21 as increased funding is outstripped by rising demand. There is a parallel £188m challenge faced by Social Care services. Whilst local organisations retain individual responsibility to deliver savings, we know that standard existing demand reduction and efficiency measures will not be enough to bridge the NHS gap. As an STP, we need both to support individual organisations in achieving their regular savings targets and, through coordinated STP action at pace and scale, to avoid a further future costs.

Elements of our triple challenge (health and wellbeing, care and quality, finance and efficiency) are unlikely to be addressed without taking action together on the wider determinants of health. To enable this we will be working closely with the West Midlands Combined Authority and have already commissioned a ground-breaking study on the economic impact of health spending. This study (commissioned through the Strategy Unit and ICF International) includes the economic impacts of health services defined in terms of both the economic benefits from improved healthcare and the opportunity costs of healthcare failures. It demonstrates how the NHS employs 6% of the Black Country and West Birmingham workforce and brings £2bn p.a. into the local economy, matched by an estimated similar value of informal care provided by friends and family members. It also models how improving infant mortality and mental health services could not only bring direct benefits to patients but could add c.£150m p.a. to the Black Country and West Birmingham economy. A summary of how we are taking forward our key initiatives can be found in the templates appended to this plan.

Aspects of these initiatives have been in development for some time (e.g. the Midland Metropolitan Hospital and the Dudley Multispecialty Community Provider model). Consequently they have already benefited from extensive public engagement and consultation. This plan, itself informed by the ongoing public and patient involvement by partner organisations, is now at the point at which coordinated engagement across the Black

Country and West Birmingham can be initiated, enabling the public to see (and to be able to contribute further to) how local plans relate to each other and how the benefits of working in partnership at scale can enhance the outcomes, experience and sustainability of Black Country and West Birmingham health services.

New Models of Care

Nationally, NHS England has been promoting a range of new models of care. These are designed to be locally appropriate ways of delivering the aims of its overarching strategy, the *Five Year Forward View*. The Black Country is active in developing a number of the new models:

- **Multispeciality Community Provider (MCP)**

  Building on and strengthening local GP services, MCPs will take a more integrated view of the needs of local populations, bringing together a wide range of services (including some traditionally provided in hospitals) and providing them closer to patients' homes. We are doing this is Dudley and in West Birmingham.

- **Primary Care Home (PCH)**

  Similar to MCPs, PCHs offer a different approach to strengthening and redesigning primary care, centred on the needs of local communities of around 50,000 people, and tapping into the expertise of a wide array of health professionals. This is the preferred model for most of Wolverhampton.

- **Primary and Acute Care Systems (PACS)**

  A local hospital also takes on a responsibility for local GP services. This is being developed in parts of Wolverhampton.

- **Acute Care Collaboration (ACC)**

  This is a model for NHS organisations offering acute care to share staff, services and resources. The Black Country is part of the Mental Health Alliance for Excellence, Resilience, Innovation and Training (MERIT), focusing on seven day working in acute services, crisis care and reduction of risk, and recovery and rehabilitation.

As we move towards a more sustainable, healthier and higher quality 2021, it is clear we already have a range of transformation initiatives underway across our patch. We will learn the lessons of these initiatives together. Through a programme of evaluation, we will reap vital learning from the seeds of innovation we have sown. This learning will be shared across the Black Country and West Birmingham and, where appropriate, across the NHS. We want to build a local health system that constantly improves itself and adapts as new learning emerges or needs change.

Public sector organisations are sometimes criticised for not doing enough to evaluate and learn from their new initiatives. In the Black Country and West Birmingham we are committed to making the sharing of knowledge and learning a powerful and accessible resource for our staff and patients. Empowering our staff, backed up with the right technology, we can make healthcare in the Black Country and West Birmingham a self-improving system that is constantly learning from what it is doing. Each aspect of our plan sets out to experiment – to test approaches, uncover effective practice, codify and spread it. Moreover, each of these initiatives is being evaluated and supported to varying degrees by the nationally regarded NHS Strategy Unit, based in the Black Country and West Birmingham, bringing a consistent discipline to both qualitative and quantitative measurement and understanding.

The Black Country and West Birmingham has the potential to transform its healthcare services and outcomes more quickly and more effectively than many other areas. Key areas of practical learning might include the following areas:

Local Place-based Models of Care

- There are two types of issue we aim to explore in this area -
  - Are there differences in the benefits that are delivered by the different models of care (MCPs, PCHs and PACS)?
  - What are the most effective ways for integrated local teams to deliver improved access, continuity and coordination of care to populations of 30,000 to 50,000? This could include evidence relating to the most effective Public Health interventions locally.

Extended Hospital Collaboration

- What level/type of joint working best enables the removal of unwarranted variation in care and outcomes?
- Does it help key hospital specialties to improve the benefits they bring to patients if they are provided in a joined-up way across more than one hospital?
- What are the key things that could most improve the quality of care in residential and nursing homes?

Mental Health & Learning Disabilities

- How can we best support service users to avoid crisis and manage their own care, improving health, social and economic outcomes?
- What level/type of specialist services can be sustained within the Black Country instead of further afield?
- Which interventions are best able to reduce unnecessary acute hospital usage by mental health service users?

Maternal & Infant Health

- What are the key things that would help us to reduce the number of unnecessary infant deaths in the Black Country?
- What mix of maternity services across the Black Country will best meet the needs of local mothers in the future?

Our 'Transformation Logic Model' overleaf sets out our rationale for why we believe that the things we are proposing to do will bring the benefits our patients and our communities need.

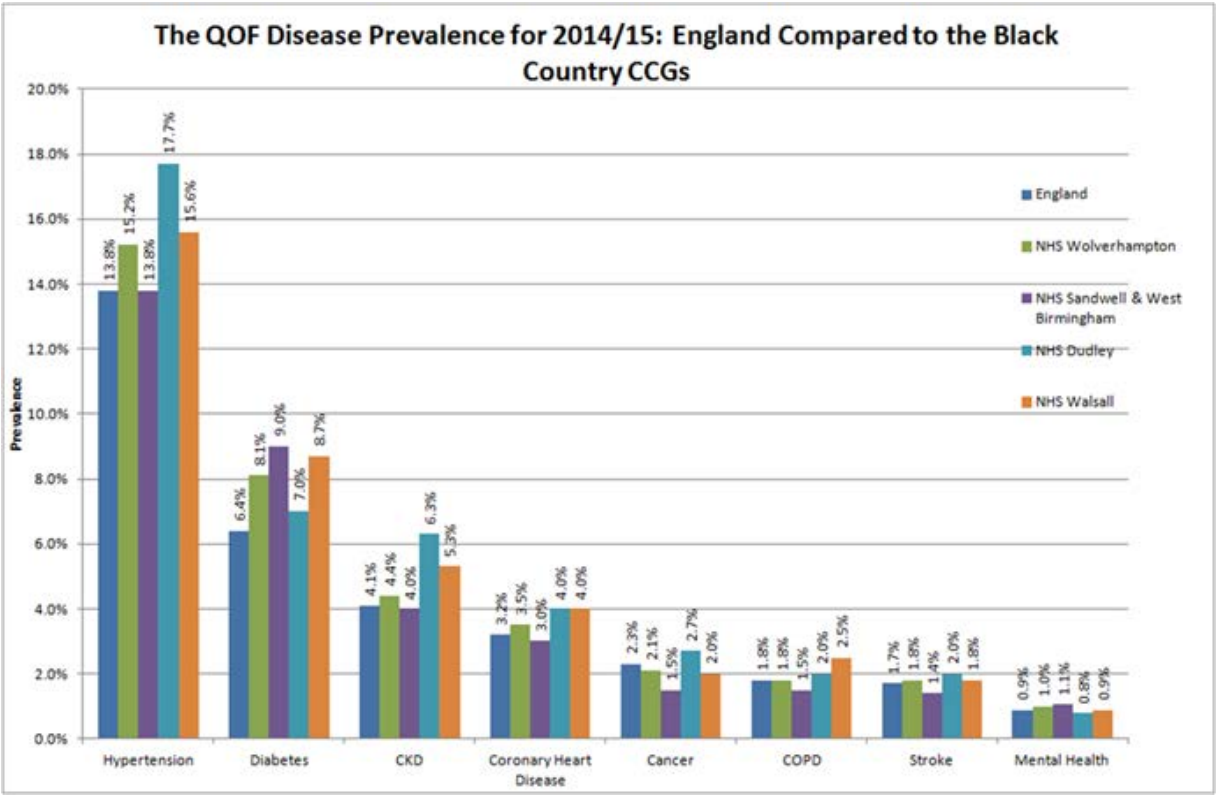
Our Transformation Logic Model

Rationale	The Black Country and West Birmingham health and care system faces significant challenges. Some of these challenges are a function of changes in population need; others are a function of the way we organise and provide services; others grow from the way we engage with patients and the public. We face resulting gaps in care quality, health outcomes and financial sustainability. We must therefore act on multiple fronts. The STP provides us with a framework for doing this. It is an opportunity to act systematically and in concert - to agree upon and address common challenges in a way that we could not as individual constituent parts.
Inputs	• In-kind contributions of all BC partners (including clinical and managerial resource) • Analytical inputs • Programme infrastructure • Additional funding allocations (including £99m Sustainability and Transformation Funding)
Activities	• 'Local Place-based Models of Care': Develop standardised place-based Integrated Care Models commissioned on the basis of outcomes; Promote the prevention agenda and build resilient communities; • 'Extended Collaboration between Service Providers': Build network of secondary care excellence; Deliver efficiencies in support services; Complete acute reconfiguration through Midland Metropolitan Hospital; Commission for quality in care homes; Deliver Cost Improvement Programmes; • 'Mental Health & Learning Disabilities': Become one commissioner for NHS services, Build the right support for Learning Disabilities in association with Council commissioning functions, Improve bed utilisation and stop out of area treatments, Deliver the WM Combined Authority Mental Health challenges, Deliver extended efficiencies through TCT partnership; • 'Maternity & Infant Health': Develop standardised pathways of care for maternal/child health; Review maternity capacity • 'Enablers': Systematically evaluate and learn from process of implementation and evidence based practice; Undertake workforce transformation and reduce agency use; Implement BC Digital Strategy; Rationalise public sector estate; Consolidate back office functions; Develop and implement future commissioning functions • 'Wider Determinants': Link to West Midlands Combined Authority to address wider determinants and maximise health contribution to economic impact
Outputs	• Proactive and efficient model of place-based care codified and commissioned • Pathways codified and streamlined / standardised • Back office / estates / supporting functions consolidated • Digital Strategy implemented • New workforce roles developed • Lessons from implementation and from the evidence
Outcomes	• Reduced unwarranted variation in care quality and outcomes • Improved patient experience (and reduced variation in) • Increased proportion of care provided in out of hospital settings • Integrated service delivery • Reduced per capita expenditure • More proactive and risk stratified care, and reduced unplanned care • More engaged and productive workforce • Better use of available public sector infrastructure • Increased use of intelligence and insight
Impacts	• A more sustainable local health and care economy • Improved quality & experience of care for the population of the Black Country and West Birmingham • Improved population health: greater quality and quantity of life • A more capable local economy, equipped for self-improvement • A happier, more sustainable workforce

The Scale of the Challenge

Better Health

Directors of Public Health have examined data contained in local Joint Strategic Needs Assessments, STP data packs and Public Health England information in order to assess the Health and Wellbeing Gap in the Black Country and West Birmingham. This analysis demonstrates that not only are there gaps between STP and England averages but that there is also significant variation within the Black Country and West Birmingham. For example, there is a wide inequality in both disease prevalence (see chart below) and life expectancy.



Our Public Health departments are already working with partners to narrow these gaps by focusing resources on ensuring that prevention services are targeted at groups and areas of greatest need:

- Black Country and West Birmingham **depression** rates (7.4%) are higher than the England average (7.3%), and are recorded at 8.6% in Dudley.
- **Diabetes** prevalence is much higher in the Black Country and West Birmingham compared to the rest of England, with Sandwell and West Birmingham reaching over 9% (England 6.4%). The percentage of physically inactive adults is 32.6% (England 27.7%).
- The **Infant Mortality** rate is much higher in the Black Country and West Birmingham compared to England rate of 4.0 deaths per 1000 - Walsall 6.8, Sandwell & West Birmingham 6.9, and Wolverhampton 6.8.

- The **Smoking in Pregnancy** rate across the Black Country and West Birmingham (linked to infant mortality) is similar to the England average (11.1%) but Wolverhampton has a rate of 15.8%.

- The **Premature Mortality** rate for Respiratory Disease in the Black Country and West Birmingham is higher than the England average rate of 28.1 per 100,000 - Sandwell & West Birmingham has a rate of 38.1 and Wolverhampton 40.9. The estimated smoking prevalence level in the Black Country and West Birmingham (20.3%) is higher than the rest of England figure (18.4%). Walsall and Wolverhampton rates are 21.5% and 20.7%, respectively.

To achieve a step change going forward, we will implement a standardised, evidence-based approach to our prevention activities across the transformation areas we have identified. This includes:

- Co-ordinated action with all partners with a focus on improving healthy life expectancy;
- Embedding critical prevention activities in place-based models of care and outcomes specifications;
- Designing common acute care pathways that focus on broad health improvement not just narrow condition treatment; and
- Tackling the rising challenge of Mental Health problems for communities through building resilience and promoting wellbeing, leading to health, social and economic benefits;
- Increasing our focus on the wider determinants of health and the impact the health and social care system can have on shaping the development of healthy, supportive environments

We have formed a Public Health Reference Group that has been focused on two key tasks:

a) Developing a common prevention framework

A common prevention framework is currently in development for use by STPs and the WMCA workstreams. For consistency this is being developed by the Association of Directors of Public Health Network (ADPH) for the West Midlands and Public Health England. The prevention framework aims to support STPs focus on prevention and early intervention to address variation and reduce the health and wellbeing gap. The framework is an enabler with a specific focus on the following three areas:

- **Changing Population Health Outcomes at Scale**. To address how to keep people healthier for longer and prevent the development of health risks;

- **Managing Individual Health Risks**. Focusing on early intervention to prevent health risks turning into ill-health and prevent escalation of existing health problems to the point where they require significant, complex and specialist health and care interventions; and

- **Better well-being by putting people at the centre of their care.** Improving quality of life and enhancing individual control by focusing on helping people to maintain good, happy, independent lives rather than being condition-focused.

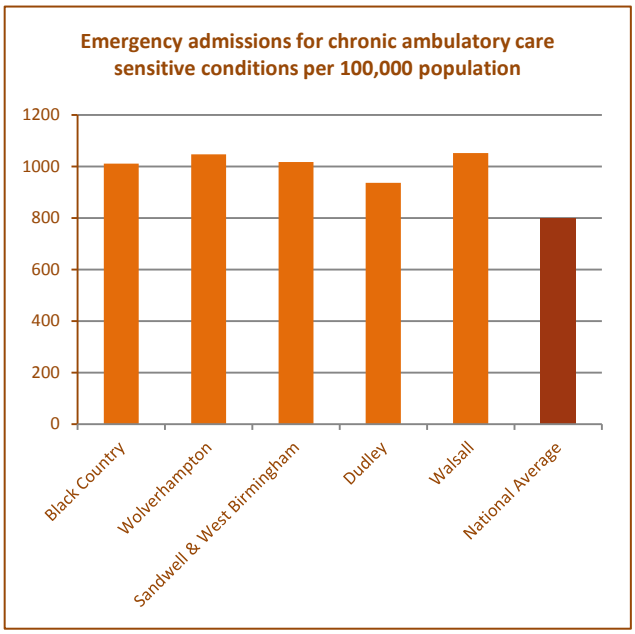
b) Providing advice and challenge across the Transformation Groups

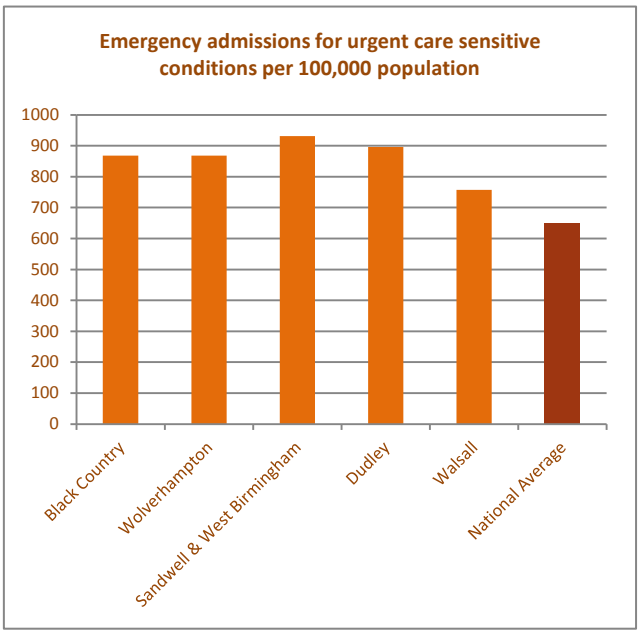
The Public Health Reference group is closely aligned to the Health and Wellbeing workstream of the West Midlands Combined Authority (WMCA) and directly links into the STP's Clinical Reference Group. In addition, it will also be closely linked to the Maternal & Infant Health and Mental Health Transformation Groups and to our joint work to address the wider determinants of health.

Better Care

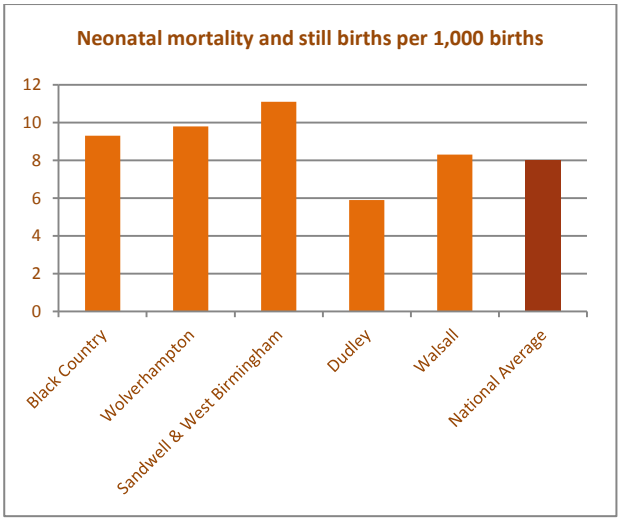
Our analysis of Care and Quality data indicates that there is unwarranted variation both between Black Country and West Birmingham performance and national performance, and also within our area.

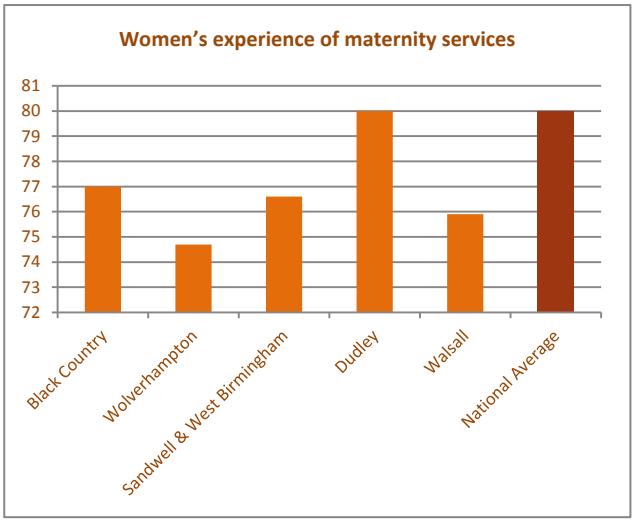
In terms of urgent and emergency care, for example, there is a 10% variation across our providers in terms of meeting the four hour waiting time target, with Black Country and West Birmingham performance in the 3rd quartile nationally (as it is for the number of emergency bed days). Emergency admissions for conditions that could be better treated in another way (i.e. through urgent care or ambulatory care) are in the bottom quartile.



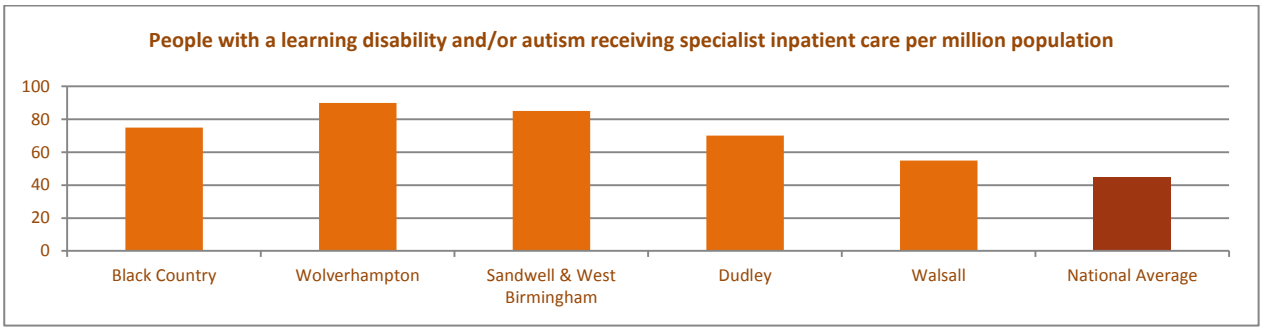


Maternity services are generally rated low in terms of mothers' experience, and the Health and Wellbeing Gap in relation to maternal smoking contributes to above average neonatal mortality. Both experience and mortality fall in the bottom quartile of STPs nationally.

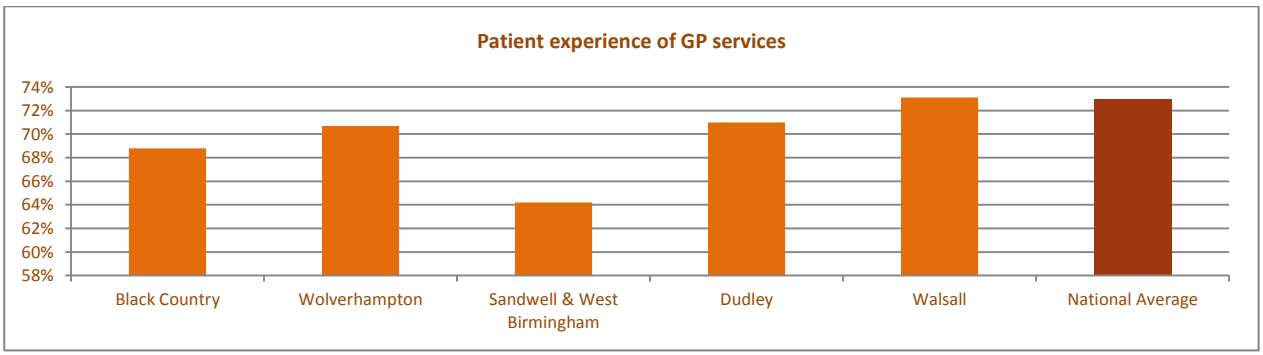




In Mental Health & Learning Disability services, there are also high rates for people with LD and/or autism receiving specialist inpatient care.



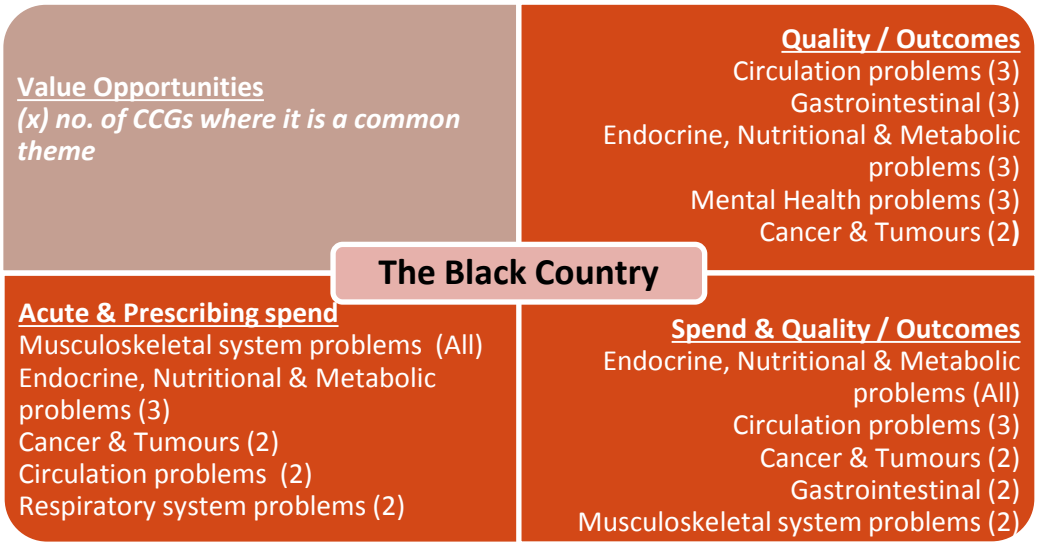
The need to standardise local place-based services is highlighted by relatively low patient satisfaction with experience of GP services.



Following this initial analysis, a Clinical Reference Group (CRG) has been formed for the STP in order to provide clinical support to our Transformation Groups in redesigning services and also to Quality Assure final clinical models, accessing external expertise where necessary. Membership of the CRG includes provider Medical Directors and Chief Nurses, CCG Clinical Leads and representatives from Public Health, Local Authorities and Pharmacists.

The CRG's work will be guided by the West Midlands Clinical Senate's Assurance Framework and will include the use of a standard template to facilitate a systematic and consistent approach. This will also enable integration with quality, equality and other impact assessment processes, as required by each proposal.

Following a review of Commissioning for Value (CfV) data and Public Health England (PHE) Health Profiles, the CRG has identified a number of clinical opportunities for improvement; key enablers and cross-cutting issues; and key challenges.



Comparison of Black Country CCGs (no.) with national averages	Significantly worse	Not significantly different	Significantly better
Hospital stays for alcohol-related harm	4		
Prevalence of opiate and/or crack use	4		
Recorded diabetes	4		
Obese children (Year 6)	4		
Under-18 conceptions	4		
Incidence of TB	3		1
Smoking status at time of delivery	3		1
Obese adults	3	1	
Excess weight in adults	3	1	
New STI (exc. Chlamydia <25)	2	1	1
Hip fractures – 65 and over	1	3	
Hospital stays for self-harm	1	2	1

a) Initial Focal Areas

- Avoidable emergency admissions:
  i. Alcohol / drug related
  ii. Frail / elderly related
- Musculoskeletal Conditions
- Long Term Conditions management

- End of Life care

b) Key Enablers and Cross-cutting Issues

- Patient engagement, activation and empowerment, and the need to help them better navigate what is often a complex health system
- Education, training & support of care home staff
- Workforce resilience & structure – use of new and/or different roles, and the potential 'sharing' of some workforce groups
- Information sharing between organisations
- Greater consistency and standardisation of social care referral processes
- Digital healthcare and access to records (with the need to address potential inequalities in access to technology)
- Linking with Mental Health and MCP vanguards in the STP
- Understanding costs to support sustainable changes.

c) Key Challenges

- Identifying the areas in which there are real opportunities for delivering a material improvement in the quality of care
- Defining key quality standards and the boundaries of what represents unacceptable variation
- Ensuring the robustness of proposals through evidence analysis, analytical modelling, etc.

To respond to these and other Care and Quality gaps, we are initiating a series of clinical service reviews that will, with appropriate public and patient engagement:

- Identify areas of best practice in the Black Country and West Birmingham and beyond which can inform the standardisation of care and quality both in localities and across hospital providers;

- Facilitate the development by commissioners, with providers, of consistent pathways and models of care across all care setting and locations

- Ensure the delivery of standardised enablers including common workforce competencies (especially in new roles); shared care records and other technology supportive of better care and self-management; and a common interface between health and social care across the Black Country and West Birmingham to reduce duplication, facilitate repatriation and reduce Delayed Transfers of Care.

- Focus on clinical areas with particular challenge or opportunity such as Musculoskeletal conditions, Cardiovascular Disease and Frailty.

- Support the promotion of prevention activities in all settings and facilitate patient activation and engagement.

Sustainability

The NHS currently spends over £2 billion each year to meet the health needs of Black Country and West Birmingham communities. Even with this investment and planned funding increases over the coming years, the demand for services is expected to continue growing even faster. As a result, the total financial gap relating to health service organisations is projected to reach £512m by 2020/21.

Local Authority budgets are subject to different challenges and constraints but it is estimated that, in relation to social care costs, the challenge will be around £188m. As with health services, this is likely to involve a combination of demand management, cost efficiency and service transformation.

The table below sets out what we believe would happen over the next five years if we do nothing to provide services more effectively and efficiently and to reduce demand for services by helping people to stay healthier:

The Black Country		Do Nothing					
		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Commissioner Surplus / (Deficit)	£000s	586	(10,154)	(76,713)	(142,758)	(208,699)	(273,318)
Provider Surplus / (Deficit)	£000s	(7,774)	(46,936)	(89,545)	(134,744)	(183,892)	(239,238)
Footprint NHS Surplus / (Deficit)	**£000s**	(7,188)	(57,090)	(166,258)	(277,502)	(392,591)	(512,556)
Indicative STF Allocation 2020/21	£000s						
Footprint NHS Surplus / (Deficit) after STF Allocation	**£000s**	(7,188)	(57,090)	(166,258)	(277,502)	(392,591)	(512,556)
Social Care And Other Surplus / (Deficit)	£000s	(0)	(0)	(67,631)	(115,428)	(155,064)	(187,698)

By contrast, if we were to successfully deliver the transformation of services described in this plan, we would not only improve the health of our populations but would also be living sustainably within our means (supported by additional Sustainability and Transformation Funds of £99m each year):

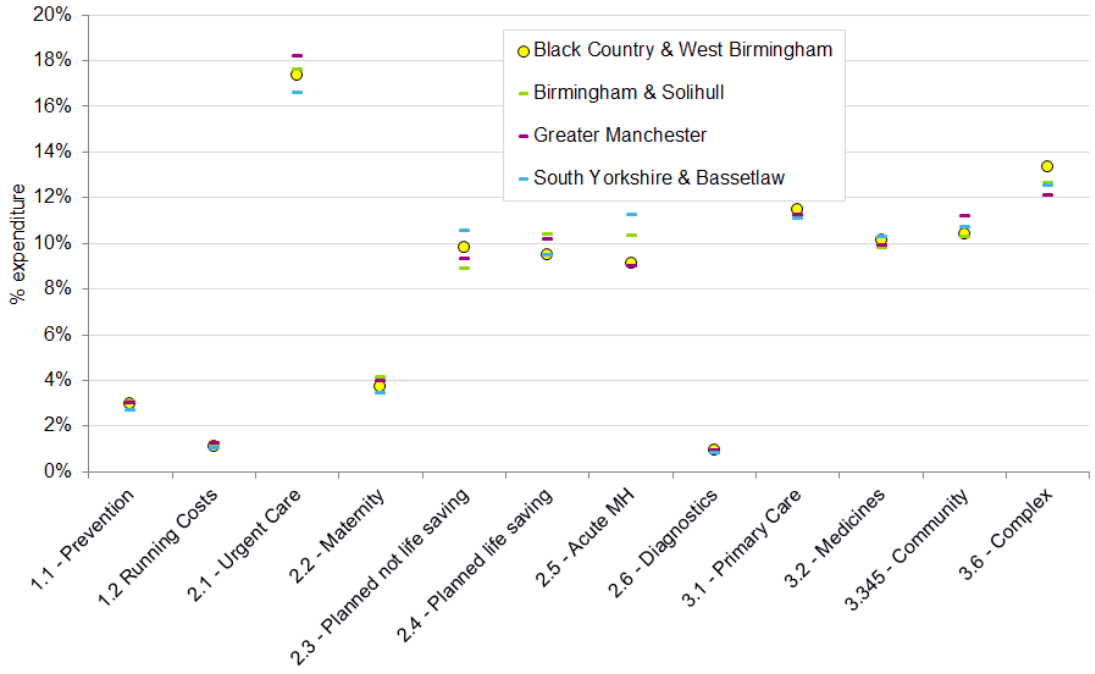
The Black Country		Do Something					
		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Commissioner Surplus / (Deficit)	£000s	586	(10,154)	(0)	(0)	(0)	0
Provider Surplus / (Deficit)	£000s	(7,774)	(46,936)	(60,773)	(71,734)	(75,029)	(99,000)
Footprint NHS Surplus / (Deficit)	**£000s**	(7,188)	(57,090)	(60,773)	(71,734)	(75,029)	(99,000)
Indicative STF Allocation 2020/21	£000s			37,100	37,100	75,029	99,000
Footprint NHS Surplus / (Deficit) after STF Allocation	**£000s**	(7,188)	(57,090)	(23,673)	(34,634)	(0)	0
Social Care And Other Surplus / (Deficit)	£000s	(0)	(0)	(55,392)	(74,755)	(88,348)	(118,926)

We have also compared our levels of spending with other STP areas (including those with the most similar populations). This has shown us that how we allocate public funds is very similar to most other parts of the country including the most similar areas (see tables below). We will further explore this analysis in the next phase of our work – for example:

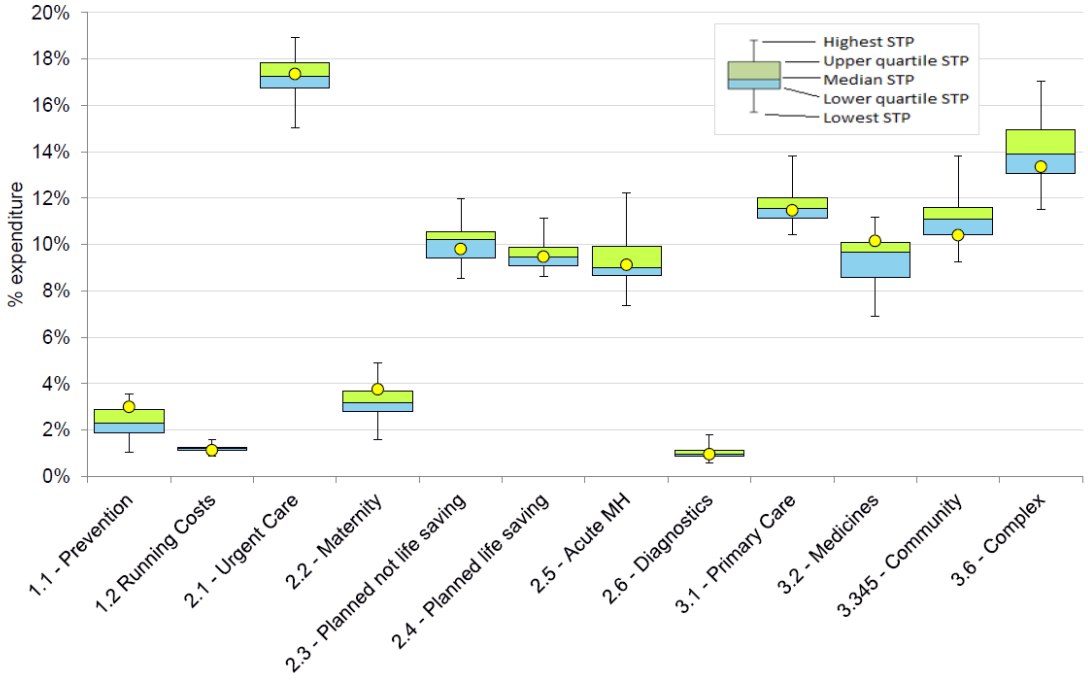
- Our administrative running costs are low;

- Our spending on complex health care needs and on primary care is high compared to our peers although we are not an outlier nationally;
- Our spending on prevention, maternity services and medicines is relatively high nationally but not unusual for our type of area; and
- Our spending on community services is relatively low, although our plans for local place-based care are expected to change this.

Distribution of Commissioning Resources 2015/16 – compared to most similar STPs



Distribution of Commissioning Resources – compared to all STPs 2015/16



When considering the sustainability of local health services, we are also very mindful that this not only relates to finance and efficiency but to some significant workforce challenges too.

- We know that a number of acute hospital specialties can be hard to recruit to across the country, and this is no different in our area. Where this is the case, we will address this as we consider how best to provide hospital services locally.

- We also know there are similar challenges faced in primary care. Delivery of the planned transformation across the Black Country and West Birmingham will provide challenges for all STP partners and success will depend upon genuine collective action. General Practice will be central to this and will play a key role designing the models for integrated delivery of services in the community and in ensuring that redesigned pathways work effectively. Current levels of manpower and capacity in General Practice increase the level of challenge. However, the STP partners are committed to an increased investment of £25m in primary care by 2020/21 to offset this challenge and to achieve the desired outcomes of the GP Forward View.

Demand Reduction through Local Place-based Models of Care

The way that health and care is provided has improved over the past fifteen years – thanks to the commitment of NHS and social care staff and, for the NHS, protected funding in recent years.

However, substantial challenges remain. The quality of care that people receive can be variable; preventable illness is common; and growing demands on the NHS means that local health and care organisations face financial pressure.

The needs and expectations of the public are also changing. Fortunately we are living longer, but we often require different, more complex care as a result. New treatment options are emerging, and we rightly expect better care closer to home.

People across the Black Country and West Birmingham are telling us that they want:

There is broad agreement that, in order to create a better future for the NHS, we have to adapt the way we do things. It means more preventative care; finding new ways to meet people's needs; and identifying ways to do things more efficiently.

We plan to achieve a step change in population health & outcomes through integrated, standardised, place-based services built around the registered list, which deliver both patient-centred and population-centred care, commissioned on the basis of outcomes not activity.

Key actions we are taking include:

- The adoption of a developmental evaluation framework that will enable accelerated implementation from a robust evidence base, transferable to other STPs;
- Mapping current intentions and models in each borough to identify best practice;
- Developing standardised access to services utilising the full benefits of the new 111 service, integrated Out of Hours (OOH) services, new digital technologies and single points of access in each community;
- Improving long-term conditions care pathways with emphasis on prevention and self-care supported by Integrated Care Teams working to the same outcome objectives;

- Creating integrated place-based teams to achieve effective care coordination for a population (patient, registered with a practice, part of a community); and
- Accelerating the learning from our vanguard sites to implement new incentive and risk management models – long-term Whole Population Based (WPB) contracts that reward improvements in outcomes for patients.

Access, Continuity and Coordination Framework

The nature and scale of need is changing radically. Analytical work, alongside extensive engagement with patients, professionals and the public has shown us that different constituents of our population require different things:

1. **Enhanced access to care.** The percentage of people in the Black Country and West Birmingham 'able to get an appointment to see or speak to someone here' decreased from 81.8% in June 2013 to 79.1% in July 2016 (GP Practice Survey). The majority of our population wants enhanced access to care. They want more flexibility in the time and mode of access - to primary care based diagnostics and to analysis that identifies and solves problems as quickly as possible - and we need to create a sustainable primary care system to deliver this. The delivery of GP services will be redesigned to facilitate patient consultation through modern technologies and digital platforms to increase access, productivity and reducing barriers associated with traditional consulting systems.

2. **Improved support for people with a Long Term Condition.** The Black Country and West Birmingham has a high prevalence of Long Term Conditions (LTC) compared with England and West Midlands averages, especially in relation to hypertension, diabetes, chronic kidney disease, chronic heart disease, depression and dementia:

Condition	England	West Midlands	Dudley	Sandwell	Walsall	Wolver-hampton
CHD: Recorded prevalence (all ages)	3.20%	3.40%	4.00%	3.50%	4.00%	3.50%
CKD: QOF prevalence (18+)	4.10%	4.60%	6.30%	4.60%	5.20%	4.40%
Diabetes: Recorded prevalence (aged 17+)	6.40%	7.30%	7.00%	8.60%	8.70%	8.10%
Hypertension: Recorded prevalence (all ages)	13.80%	14.80%	17.70%	15.50%	15.60%	15.20%
Number of adults with dementia known to GPs: % on register	0.74%	0.73%	0.76%	0.69%	0.77%	0.82%
Number of adults with depression known to GPs: % on register	7.30%	7.60%	8.60%	6.90%	7.80%	7.90%
Stroke: Recorded prevalence (all ages)	1.70%	1.80%	2.00%	1.70%	1.80%	1.80%

Those being supported to live with a health condition (especially LTCs), need improved continuity of care. They need more consistent and proactive services that support them to manage their conditions and achieve their goals. They have needs (mental and physical) that are interdependent and that change, and they expect

services to reflect these needs. As a result of these factors (both prevalence and lack of continuity of care):

- Emergency admissions for chronic ambulatory care sensitive conditions per 100,000 population were 26% higher in the Black Country and West Birmingham than the England average (1,011 compared to 800) (STP Footprint data pack); and

- By moving to the upper quartile of comparable CCGs, savings of £4.6m could be made across the Black Country and West Birmingham (Identifying Potential QIPP Opportunities, Strategy Unit, 2015)

For these patients, self-care should be supported by enhanced primary care in order to keep patients better at home for longer by helping them to understand their condition and how it may exacerbate, and what to do about it if it does. Continuity of care embraces not only primary care but also community care (designing and delivering services closer to home), acute care (enabling hospital teams to discharge patients back to community care for rehabilitation or continuing care closer to home) and mental health services.

3. **Better Coordinated Care.** Some, notably those with complex care needs, multiple co-morbidities, those with frailty and those nearing the end of life, need better coordinated care. We know that the majority of health spending occurs in the last years of a person's life, when many have complex care needs:

    - The number of people with comorbidities is set to increase in England from 1.9 million in 2008 to 2.9 million by 2018 (Long Term Conditions Compendium of Information: Third Edition, Department of Health, 2012).

    - The number of people aged 75 and over is projected to increase by 10.4% between 2016 and 2021 from 105,000 to 116,000 (2014-based Subnational Population Projections for Clinical Commissioning Groups in England)

    - The cost of social care and inpatient admissions in the last year of life was £18,621 (£8,649 inpatient, £9,972 Social Care) (Social care and hospital use at the end of life, Nuffield Trust, 2010).

    These vulnerable people need the services that are supporting them to work closely together, integrating (rather than duplicating) care closer to home and improving the experience of it. Unfortunately, too many of these people are ending up in hospital in a crisis and being admitted to a hospital bed which potentially could be avoided with the right services in the community:

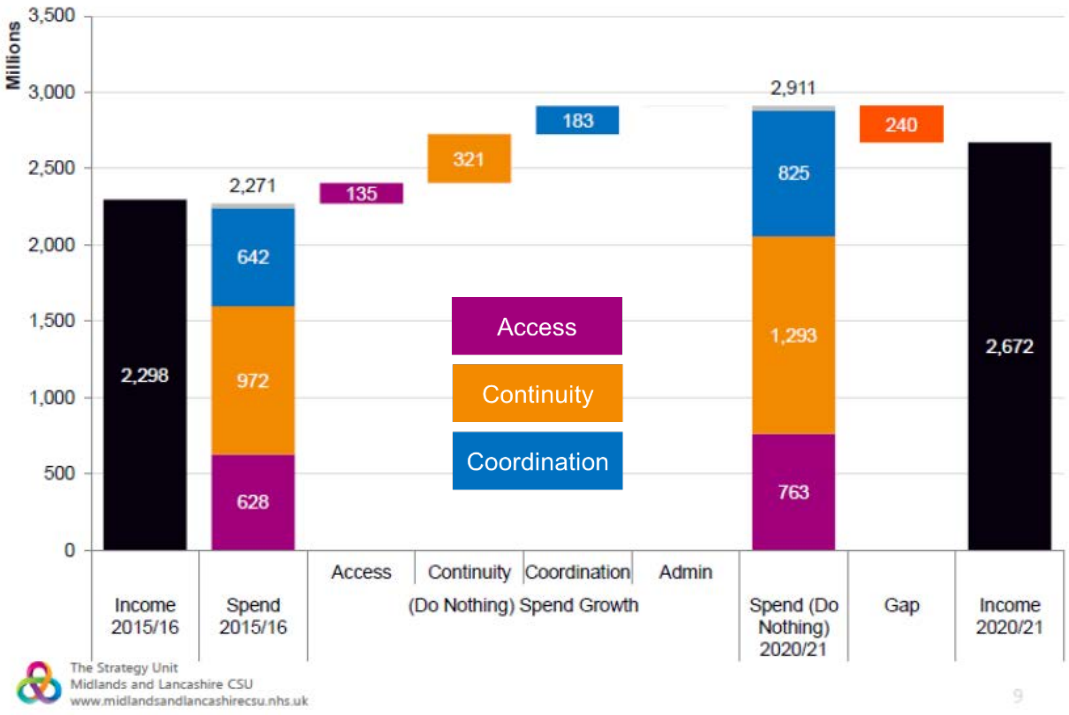
    - Across the Black Country and West Birmingham Emergency Admissions for frailty and ambulatory care sensitive conditions are amongst the worst in the country.

- In 2014/15, there were 28,530 admissions for ambulatory care sensitive conditions (acute, chronic and vaccine preventable) in the Black Country and West Birmingham costing £57.6m (Identifying Potential QIPP Opportunities, Strategy Unit, 2015).

Although this is a small cohort of patients, the current ways in which services are provided results in us spending a large proportion of our resources inefficiently. Effective care planning, taking into account the whole needs of the person, is essential to ensure all individuals supporting a person's care work effectively together and help people maximise the use of their social networks in their community, reducing social isolation and reliance on statutory care.

While the nature and scale of demand is changing, the supply of care is highly constrained and remains largely unreformed. The financial challenges facing the NHS are well documented; this places important limits on supply of care. But fundamentally, changes in the mode of provision have not kept up with changes in need. Providing care to an ageing population with multiple chronic conditions is a radically different proposition to supplying the predominantly episodic and curative interventions that typified the care of the past. Services are not configured to meet this fundamental shift. Nor are they sufficiently well integrated. With differing solutions to this problem in each place, Black Country and West Birmingham Health and Care organisations are working together to share best practice and experiences of addressing these challenges, in partnership with people who need us to address those most.

We have developed a framework that captures the scale of the local financial and activity challenge in relation to three key care areas. The following waterfall diagram sets out the challenge facing the STP's Clinical Commissioning Groups (CCGs) in terms of these areas:



Local Place-Based Care Models

The people of the Black Country and West Birmingham are at the heart of our plans. There may be different solutions in each of the four STP areas. This is the right thing to do, working with each community to shape what those solutions are. However, our collective aim is to help them flourish: to support them when they need support; to guide them when they need guidance; and to promote independence throughout. They are individuals and citizens first, patients and service users second. Our whole approach starts with this understanding.

Key enablers are the assets of the Black Country and West Birmingham People:

- Building on self-care in a more proactive manner by engaging and activating patients not only to contribute to their own health and wellbeing but also to support others to do the same;
- Building strong, resilient communities and connecting people together, reducing social isolation; and
- Maintaining a strong Voluntary Sector.

We will reprioritise prevention, to identify and focus on issues upstream rather than tackling them at the point of demand. This will include a renewed focus on population health measures such as smoking rates, obesity and mental health.

The place based care work stream addresses the imbalances in supply and demand. It rests upon the unique position of primary care - starting with the person, registered with the practice. The role of the GP is therefore fundamental. They take overall responsibility for the care provided by other services. Across the Black Country and West Birmingham these services include multi-disciplinary teams (MDTs), a wider network of community based and voluntary sector services organise around localities, and the services provided on referral to secondary care.

The delivery of GP services will be redesigned to facilitate patient consultation through modern technologies and digital platforms to increase access, productivity and reducing barriers associated with traditional consulting systems. All patients accessing health whether through acute minor ailments or more complex chronic pathways should have underpinning support.

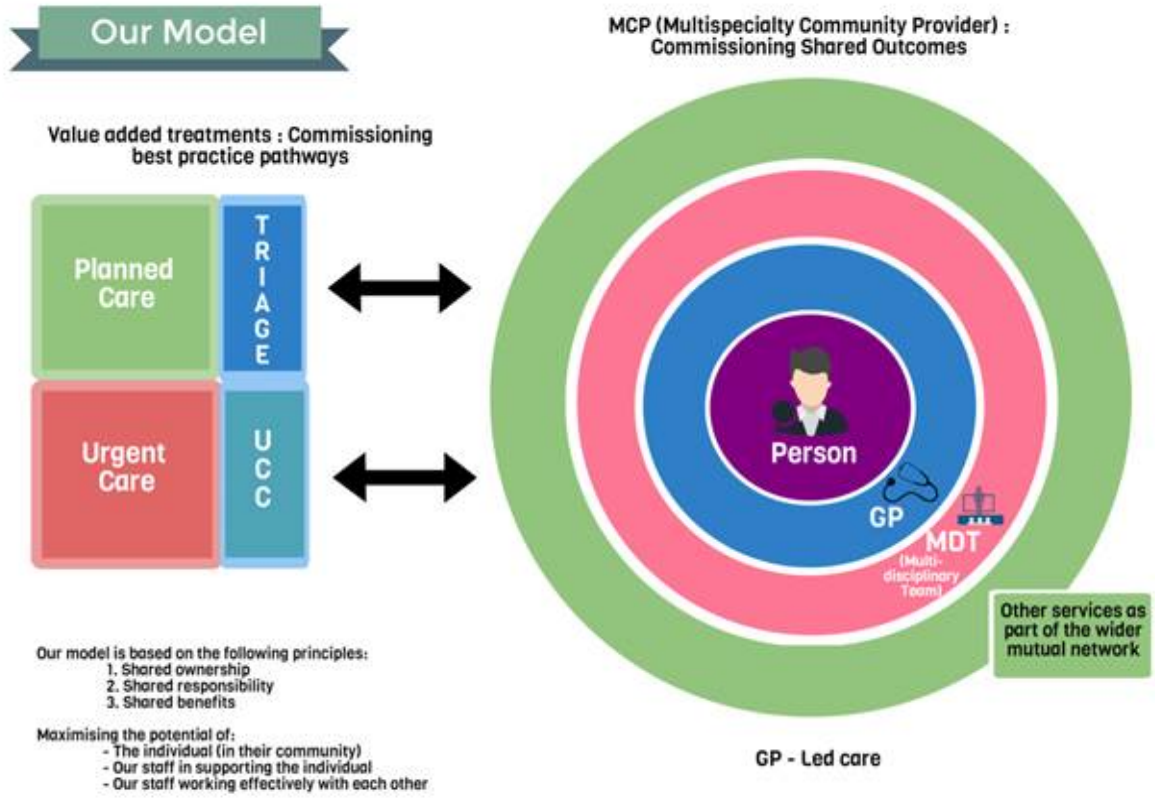
Supporting the benefits of modern hospital care, the new care models allows secondary care to focus on acute care of the unwell or injured, alongside appropriate elective activity for procedures which must be undertaken in a hospital environment. Hospital staff and teams can discharge patients back to community care in confidence of excellent local services delivering rehabilitation or continuing care closer to home.

The work stream will also tackle the variation in care, standardising pathways to best practice to deliver maximum efficiency of resources and delivering the highest quality care.

Our STP has a high density of new care model initiatives from which initial learning can be shared to accelerate implementation across the whole STP and more widely. Each model represents a locally-appropriate means of implanting an overarching, shared place-based model of care, in line with our principle of subsidiarity.

Dudley

Dudley's new care model proposes GP-led, integrated care in the community through the development of a Multi-specialty Community provider (MCP). A new approach to continuity of care and standardising access to services will provide a return on investment as it will improve the efficiency and effectiveness of primary care; improve self-determination by the public; contain the rising demand for emergency & planned secondary care - and thus improve efficiency of the overall system.



Our model rests upon the unique position of primary care - starting with the person, registered with the practice. The role of the GP is therefore fundamental. They take overall responsibility for the care provided by other services. In our model, these services include multi-disciplinary teams (MDTs), a wider network of community based and voluntary sector services organised around Dudley's five localities, and the services provided on referral to secondary care. Key actions planned include:

- Develop new ways of working to support the future MCP through:
    - Successful multi-disciplinary teams across all of our 46 General Practices;

- Voluntary sector Locality Link Workers, providing access to community-based support;
- Telehealth pilots in two practices covering 34,500 patients;
- Rollout of mobile devices to all GP practices, enabling remote access to core patient systems during home visits and better coordination at MDTs;
- A new Dudley Outcomes for Health long term conditions framework;
- An IT Local Delivery Roadmap towards integrated care records by 2020;
- Scoping of services, outcomes and characteristics of the MCP.

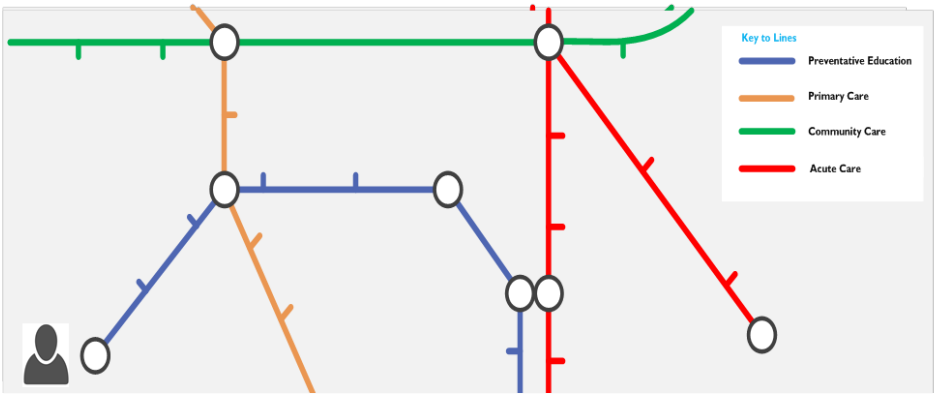
- Award a contract for Dudley MCP early 2017/18 which includes :
  - A meaningful outcomes framework to measure improvements in population health supported by a clear and robust evidence base, transferable to other STPs;
  - Standardised access to services utilising the full benefits of the new 111 service, integrated OOH, new digital technologies and single points of access in each community;
  - Improved long-term conditions care pathways with emphasis on prevention and self-care supported by Integrated Care Teams working to the same outcome objectives;
  - Integrated place-based teams to achieve effective care coordination for a population (patient, registered with a practice, part of a community).
- Accelerate the learning from our vanguard site to implement new incentive and risk management models – long-term Whole Population Based contracts commissioning for outcomes across the STP footprint.

All of the above will be underpinned by on-going involvement and public consultation (where necessary) with local people, and we will fully engage with all staff involved in the transition to the MCP.

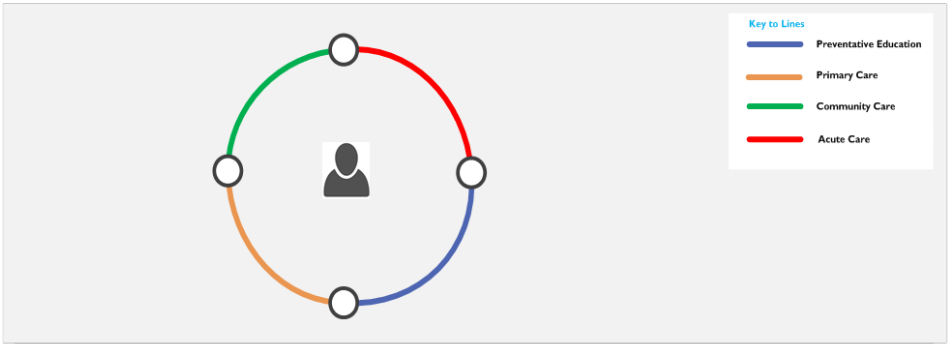
Sandwell and West Birmingham

The vision is to transition to outcomes based commissioning, which may take the form of a single, or multiple, accountable care organisations. These organisations will be accountable for both the costs and outcomes of their whole populations. The CCG will hold contracts with these organisations that will promote innovation and the delivery of effective and joined up care.

Patients travel through a system that is not designed around them, there are lots of changes and different routes and it can take a long time to the end point.



New Care Models provide the opportunity to design an approach where clinicians work together ensuring connections are made between care



Key actions planned include:

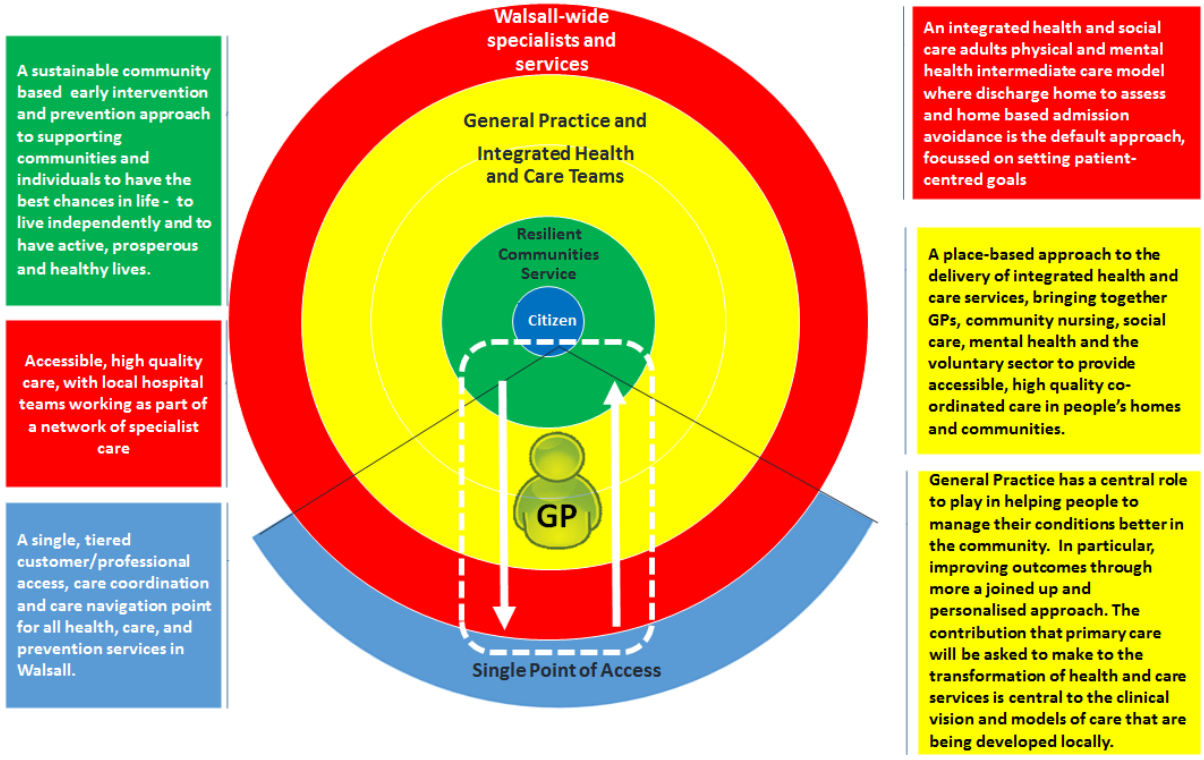
- Use the foundation of community nursing redesign and Primary Care Commissioning Framework to scope population coverage
- Develop the Whole Population Budget and the scope of services to be included
- Develop standardised access to services utilising the full benefits of the new 111 service, integrated OOH, new digital technologies and single points of access
- Improve long-term conditions care pathways with emphasis on prevention and self-care supported by Integrated Care Teams working to the same outcome objectives
- Accelerate the learning from our vanguard sites to implement new incentive and risk management models.

Walsall

Walsall aims to develop health and care services in the community that empower children, young people, adults and older people to live happier and healthier lives. Key actions planned include:

- We will support citizens to develop and harness the assets in communities to further develop a prevention and early intervention offer that keeps people well and independent in their own communities;

- We will simplify, integrate and standardise access to health and care services, ensuring quality and value through the commissioning of best practice pathways. This will include urgent care services (111 service, integrated OOH, new digital technologies and single points of access);
- We will tackle unwarranted variation in the care and treatment of people with on-going health and care needs;
- We will create integrated health and care teams, with general practice at the centre of care provision and supported by specialists working in the community, to provide multi-disciplinary co-ordinated care to people with complex health and care needs; and
- We will work together as system leaders to ensure that the resources and assets that we have in Walsall are most effectively deployed and have the necessary capabilities to deliver the new care model.



Wolverhampton

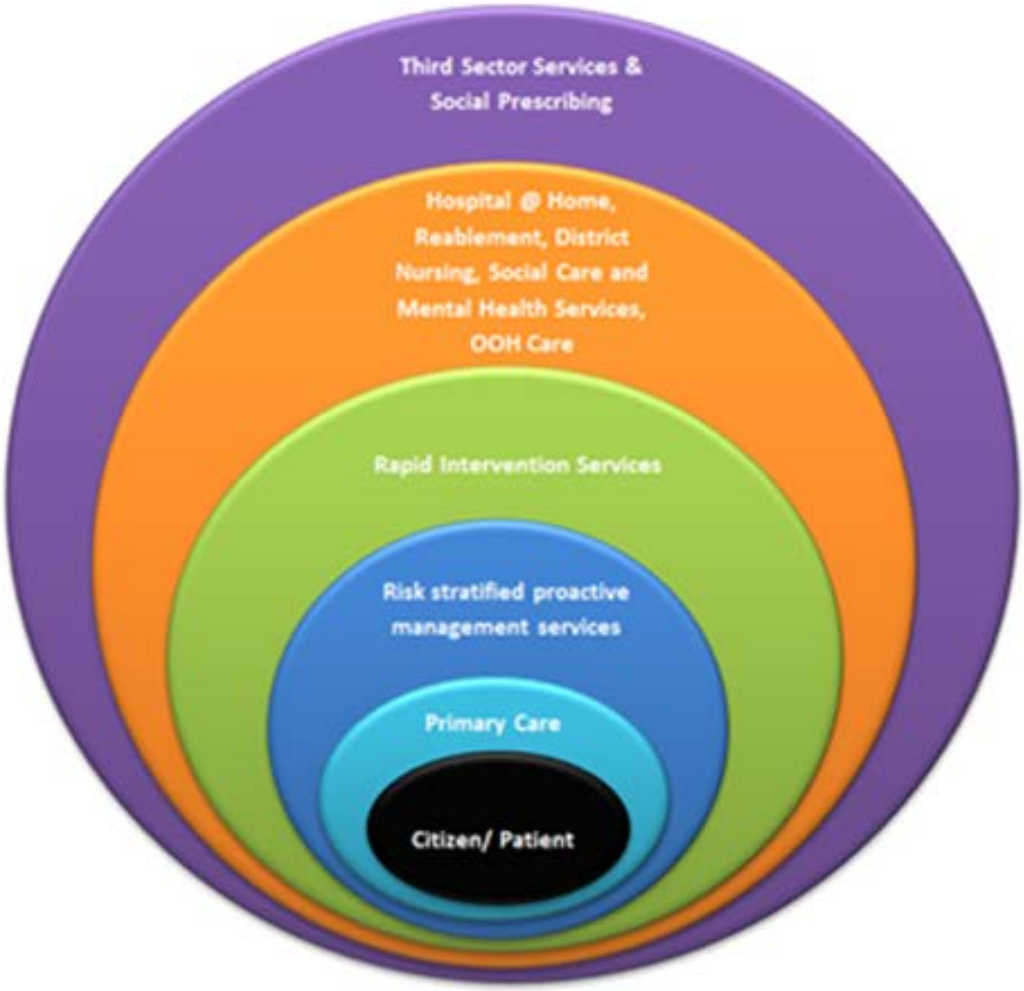
Wolverhampton CCG's aim is to promote the health and wellbeing of our local community that is standardised & commissioned in line with the registered list(s). We will do this by learning from models of care emerging both locally and nationally – including our local Primary Care Home (PCH) test site and Primary and Acute Care System (PACS) pilot. As we move into contracting year 2017/18, it is likely that an alliance-type MCP contract will become the vehicle through which community delivered services are commissioned.

The agreed approach will focus on health and care delivery models that are in the best interests of people living in the City.

There will be a greater focus on outcomes based commissioning including those that promote independence health and wellbeing but also be responsive to the needs of individuals with deteriorating independence.

We will reduce demand on services traditionally provided in the hospital setting and provision of alternatives to out-patient appointments to improve waiting times, diagnosis & treatment that can be achieved through shared decision making, advice and guidance and patient choice.

We will seek to ensure that our population receives the right treatment at the right time and in the right place. Care will be patient and population focused, reduce early deaths, improve quality of life of those living with long term conditions and reduce health inequalities. With Patient and GP Primary Care services at the core of the delivery model, many of the services are already in place.



Key actions planned include the development of new ways of working supported by integrated teams as the MCP or PACS model evolves, such as:

Access:

- Implement training for care navigators intercept & guide patients to the health & social care professional that best meets their needs whilst maximising social prescribing opportunities at primary care level;
- Improve access to services based in primary care including direct access to diagnostics identified through peer review, patient choice and shared decision making;
- Access to a full range of standard primary medical services during core hours and essential services 24 hours a day 7 days a week through a combination of primary care and extended out of hours service provision with access to central patient records and where feasible non face to face consultations using various media (skype, email, telephone); and
- Strengthen access to services utilising the full benefits of the new NHS 111 service, integrated out of hours, digital technologies and single points of access.

Care Co-ordination:

- Develop home based care including provision of hospital at home, community intermediate care, reablement, rapid response, therapy services and support from the third sector;
- Implementation of local strategies for Intermediate Care, End of Life, Ambulatory Care, Mental Health and Primary Care to maximise opportunities for place based care;
- Extended MDTs providing consultant outreach for diabetes, respiratory, mental health condition initially, extending a broader range of disease conditions; and
- Practices working together at scale with community neighbourhood teams that ensure coverage across the city for patients at highest risk of admission to hospital

Continuity:

- Ensure appropriate & timely support in line with our Integrated Care Strategy to support hospital discharge, prevent admission to hospital, avert potential care home admission, identify support that is suitable to meet the needs of individuals;
- Reduce demand on services traditionally provided in a hospital setting and provision of alternatives to out-patient appointments to improve waiting times, diagnosis & treatment achieved through shared decision making, advice and guidance and patient choice; and

- Improved long-term conditions care pathways with emphasis on prevention and self-care supported by Integrated Care Teams who are striving to achieve the same outcomes.

To support the above we will develop and implement a local Quality Outcomes Framework that seeks to achieve the highest standards of care quality, value for money & maximises opportunities for groups of practices to work at scale. This is work in progress and will be developed further with partner agencies and stakeholders.

Expected Impact

Each local area's implementation approach will contribute to the achievement of the overall benefits required in relation to access, continuity and coordination.

To support the delivery of these benefits we have identified £34m of capital investment in primary care premises over the planning period, with a further £16m capital to support the provision of services closer to patients' homes.

Pending confirmation of national metrics, the Black Country and West Birmingham expects its local, place-based plans to deliver the following benefits:

Category	Expected Benefit
Better Health	• Reduced LTC prevalence • Reduced mortality • Reduced social isolation • Increase in people dying in the place of their choice
Better Care	• Improved access, coordination of care, and patient experience of GP, community and other placed-based services • Clinical outcomes will be improved via MDTs, LTC care pathways and standardising access to care • Patient experience improves through co-production & patient activation; and by delivering more efficient & holistic care • Minimise harm (reduce number of incident per person / per practitioner). Safety/quality of the service will be safeguarded through standardised access and pathways; improved communication and reducing variation
Sustainability	• Reduction in emergency bed days, admissions for ACSC, and use of acute beds, nursing and social care placements • Resource sustainability will be realised through changing culture and behaviours, increased efficiency and improved staff retention • Reduction in emergency bed days, admissions for ACSC, and use of acute beds, nursing and social care placements • Improve staff efficiency, morale, patient contact time

Efficiency at Scale through Extended Hospital Collaboration

Our provider organisations have challenging Cost Improvement Plans (CIPs) in place for 2016-17. In order to meet the ongoing provider sustainability challenge beyond 2016-17 we will enable shared learning between providers so that individual CIPs can continue to be delivered. Much more than this, however, we will deliver a scale of efficiency beyond the reach of individual providers through coordinated action to develop networked and/or consolidated models of secondary care provision. As plans continue to develop, the impact on our hospitals of any new contracting models (e.g. Dudley MCP) will also be assessed.

We recognise that improving acute hospital services may require adjustments to be made to hospital sites, and we have allocated capital investment of £35m during the planning period to support this, along with a further £3m capital relating to organisational estates efficiencies of some £10m a year.

Creating Networks of Secondary Care Excellence

Reducing Variation

We have significant opportunities to share best practice and remove variation. Our initial analysis highlighted the following service areas:

1) Trauma & Orthopaedics – *Better Care, Better Value* (BCBV) indicates £2.7m could be saved through reducing first to follow up ratios and £0.9m through reducing pre-procedure bed days.

2) CVD (Including CHD, Renal, Stroke, Diabetes Pathways) - BCBV Cardiology indicates saving up to £2.4m. BCBV Nephrology saving of £2.3m. BCBV Endocrinology saving of £0.62m.

3) Respiratory - BCBV Respiratory Medicine indicates saving of up to £0.9m.

4) Cancer – BCBV Clinical Oncology: £2.03m. BCBV Medical Oncology: £1m (specialised services changes).

We have a plan of action covering 6 phases (see table below), and these represent the sustainability challenge which is amenable to shared actions by the relevant organisations. Together they amount to a major programme of concerted change. We will build from extant clinical leadership arrangements to see it through and ensure learning from other systems that are ahead of us.

We already have networked services in a number of areas – radiology, ENT, rheumatology, vascular surgery, and stroke. By ensuring that all services supporting acute care operate to common standards we will tackle variation. By 2019 we will operate 4 A&E departments, ranging from 75k to 150k attendances in each. To succeed we may need to share expertise

and increasingly to develop rotational programmes of learning and staffing across those sites. All 4 sites will have to deliver for us to succeed.

Phase	Deliverables
A1	Develop single service plans for less-acute surgical disciplines: including plastics, ophthalmology, and urology.
A2	Complete extant work to get shared pathology vision including rationalisation of histopathology.
B1	Develop shared collaboration plans for paediatric services on a network basis.
B2	Create collaboration model of providers to support acute general surgery across 4 A&E departments
C1	Develop shared service plan for orthopaedics, based either on sub-specialised rationalisation or service relocation.
C2	Establish shared maternity and neonatal model of care to meet CQC / RCOG guidance.

Service Sustainability

In addition, we have commenced a review of specialties and/or sub-specialties that face sustainability challenges and there may be opportunities to consolidate volumes. These include:

- **Rheumatology**. We have already well advanced discussions regarding Rheumatology service, unsustainable in Walsall due to small size of service making recruitment and retention of consultant rheumatologists really difficult. As a result of our network approach, we have collectively made available short term resources to sustain the service, and have been successful in recruiting 3 consultants who will join later this year. This will lead to a reduction in locum spend in the second half of the year. RWT already provides Rheumatology services for a large part of Staffordshire as well as Wolverhampton.

- **Urology**. While all Trusts have sustainable Urology services, this is a great example of where we have moved on to consider clinical and financial sustainability at a sub specialty level. Having comprehensively mapped services at a granular level, we are now defining specialised service pathway changes to consolidate volumes in particular areas. These will maximise certain consultant interests and make the best use of out of expensive treatment platforms. Discussions are taking place to widen this work to incorporate all Trusts within the Black Country and West Birmingham.

- **Neurology**. We have established a multi-disciplinary team to explore how we might improve sustainability of neurology services across the Black Country and West Birmingham. As well as exploring joint consultant posts to sustain current services, we are exploring together how we might make better use of sub specialty skills, how we might develop workforce to increase the provision of Nurse led services (MS, Complex Headache, Epilepsy) which in turn will we believe reduce pressure and

demand for acute, consultant led FU clinics. WHC is addressing current recruitment difficulties through a joint arrangement with UHB.

- **Out of Hours / 7-day services**. All Trusts are examining implementation of the four key standards by March 2017, RWT being an early implementer of these standards, and together we have begun to explore the opportunity to collaborate on closing 7-day service gaps and provide better out of hours cover. We have already established a joint rota for non-vascular interventional radiology (nephrostomy) and will examine extending to other areas. We will explore other areas where more specialised / lower volume services may benefit from a networked approach, for example ENT and Plastics and in particular, breast reconstruction.

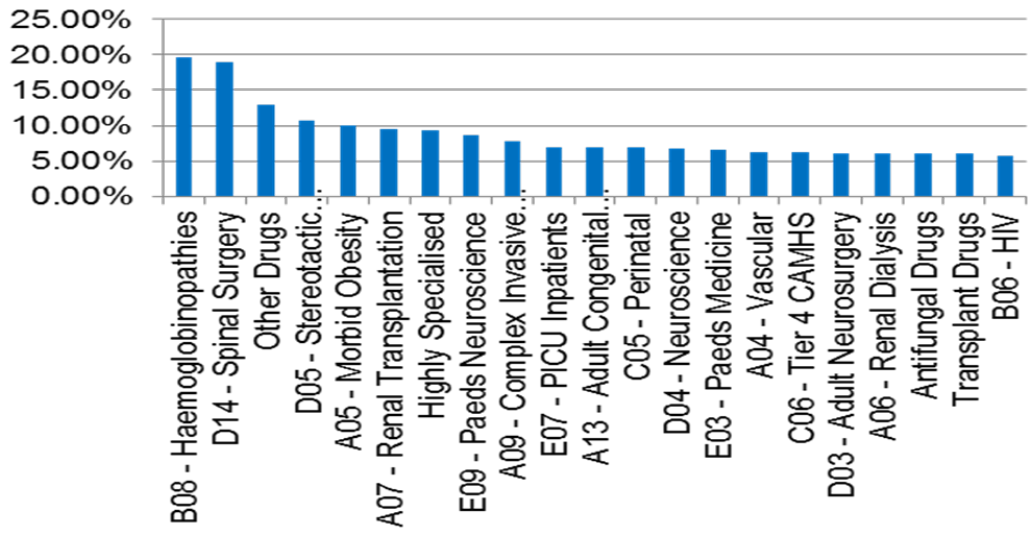
- Other areas include Upper Limb Trauma, Cardiology, Audiology, Children's and Community Services. We will also explore replicating some services across the path and scaling some services, both of which will enable improved clinical and financial sustainability.

Specialised Services

Certain services are commissioned directly by NHS England rather than through local CCGs. To support the integration of pathways and the devolution of some specialised services it is proposed that a Specialised Commissioning Board will be established for the West Midlands.

Midlands and East Specialised Commissioning will work with the Black Country and West Birmingham STP to plan for the development of new models of care to support specialised services. Over the five years of the STP this will involve looking at what is the appropriate level of planning and delivery for individual specialised services. Central to this process will be the development of networked models of care that allow geographically dependent services to be managed by Tier 1 and 2 providers.

The table below illustrates the demand and cost challenges faced in relation to fastest growing specialised services in the Black Country and West Birmingham:



To address these challenges in the current year, the West Midlands Specialised Commissioning hub has a QIPP target of £36.3 million. Schemes are split between 70% transactional and 30% transformational with 90% of these being local schemes and 10% nationally identified schemes. QIPP plans for 2016/17 are currently forecast to deliver a balanced plan. Moving into 2017/18, The QIPP target for the West Midlands in 2017/18 is: £36.9 million Schemes will be split 60% transactional and 40% transformational to reflect the national drive towards more transformational, whole system change. The proportion of this QIPP for the Black Country STP based on presumed population split is £9.23m. These plans are also expected to affect the STP's other Transformation Groups, as indicated in the table below:

STP Transformation Group	Specialised Commissioning Transformation Project		
	National	Regional	West Midlands
Local Place-based Models of Care			Spinal Pathfinder/ Future contracting at Level 1 and 2 providers
Extended Hospital Collaboration	Cancer Alliances	Vascular Review	Neonatal Review
Mental Health & Learning Disabilities Services	Transforming Care Mental Health Service Review		Adult Secure ACO CAMHS ACO
Maternity & Infant Health			Neonatal Review

Efficiency in Clinical and Non-Clinical Support Services

Pathology

The four integrated care trusts within the Black Country STP all currently provide a full range of pathology services covering inpatients, outpatients and local community GPs, both hot & cold, that include microbiology, histopathology, blood sciences, immunology, anticoagulation and clinical haematology. All departments are CPA accredited and are currently going through the UKAS accreditation. The Blood Banks have MHRA accreditation and the mortuaries hold HTA license for scheduled activities. All Trusts have in existence or are committed to entering into Managed Equipment Service arrangements which may constrain timing of consolidation. All 4 trusts will require continued access to 24/7 hot lab capabilities regardless of any other consideration.

The Black Country STP sets out a simple triple aim to improve health outcomes, healthcare experience and make the best use of the resources we have. We have an ambition to offer a first class UKAS, MHRA, HTA accredited pathology service across the Black Country and West Birmingham that ranks in the top quartile nationally on a range of quality, efficiency and outcome measures. This will include speed of access to results for inpatients to enable

earlier decisions on treatment and so reduce length of stay (LOS), improved turnaround times for all pathology tests and appropriate out of hours coverage to reduce 7 day service gaps.

We believe that IT will be an enabler to integration of services. Currently 3 of the four trusts use Sunquest ICE for requesting and results view. A common system would allow for sharing of results across the Black Country and West Birmingham. The procurement of a common LIS would allow the laboratory services to further integrate and create a virtual laboratory, which would be an enabler for further change; however this would require significant investment. All four trusts currently provide the full range of District General Hospital (DGH) pathology services locally along with some more specialist work for a larger area. The wider STP service strategy for the Black Country and West Birmingham commits to maintaining four acute sites (five currently – four following the opening of Midland Metropolitan Hospital), and so any solution proposed must be cognisant of and consistent with this baseline.

We are examining the case for a shared molecular laboratory and explore together Digital Pathology to support specialist and sub specialist reporting, improved (virtual) multi-disciplinary team (MDT) provision and deliver efficiencies from use of latest technologies. We believe this will enable some of the work we are doing across a range of services at a sub speciality level which we believe is a core part of the route to clinical and financial sustainability.

We have already established a team comprising clinical and operational colleagues who are currently working on collaborative solutions to the sustainability of Histopathology and Microbiology services initially. Initial focus has been on service level agreements (SLAs) to stabilise services and enable some joint recruitment to reduce locum demand and improve resilience.

We have commissioned an independent expert review of our pathology services. Trust Chief Executives have identified a suitable, credible, expert (Dr Mark Newbold) who is undertaking this work, and Terms of Reference have been agreed by all four Trusts. The STP has engaged fully with the national process around pathology integration.

All four Trusts are committed to considering all options that will lead to clinically and financially sustainable pathology services. All options will be fully considered. While examining various design principles and being open minded on solution options, we will in the meantime continue to build out on extant plans and focus on the functional changes that will enable sustainable services across the patch. Our review will include examining successful models from elsewhere as well as learning from unsuccessful lab mergers. Our outline plan is as follows:

- November – December
  - Build options and assess case for each, mobilise quick win delivery
  - Determine preferred option(s)

- Q1 2017
    - Deliver quick wins
    - Build detailed plan and business case for detailed options
    - Sign off business case
- Q2 2017 – Delivery / transition

Together in addition to the ambitions outline above, we will examine the case for further development of Managed Service Contracts (MSC) to allow new technologies to be introduced and more efficient procurement of consumables. We will accelerate possible consolidation of some referred tests to enable critical mass to be achieved to drive short term savings, and we will examine opportunity for consolidation of out of hours cover, i.e. Microbiology, as a route to short term benefit.

In seeking to move at pace and scale to realise maximal efficiencies in clinical support services, we are also mindful of the risks involved, including:

- The pace of change may be constrained by the financial and intellectual headroom to focus on planning and delivering the above at the same time as continuing work on STP, local vanguards, CIP and of course, seeing & treating ever increasing numbers of patients;

- As in other examples across the country, rushing to consolidate services may create more problems than are solved;

- Transactional costs associated with moving to consolidated models, dual running costs associated with changing service delivery models and the opportunity cost associated with distracting resources from other priorities will make the value case for change harder to make, and resulting in long period of pay back or inability to fund the change;

- Consolidation may have adverse morale impact on leaders & teams, which may lead to deterioration in service levels if colleagues leave as a result;

- Reconfiguring the use of PFI space for labs across the patch may lead to expensive change; and

- Pathology consolidation that is undertaken without full clinical engagement and without consideration of clinical strategy or which is not in alignment with patient pathways can result in (inter-provider) confusion, disruption in patient journey, delay in patient management, poor patient experience, transmission mistakes, repetition of tests with waste of resources, overall deterioration in quality of service and/or other clinical risks.

We believe we could mitigate the risks above and go further, faster if our work is supported by:

- Provision of national exemplars where consolidation was conceived, planned, delivered and sustained;
- Funding to increase project management office that can provide cohesion, grip and drive to accelerate the work;
- Funding for enablers that are identified during the assessment and planning phase of the work above. Examples being the technology to enable interoperability, digital reporting and molecular capability;
- Clarity on prioritising the sometimes conflicting requirements - short term versus long term targets; run rate reduction versus investment required to achieve; increase staffing to achieve Care Quality Commission (CQC) standards versus pressure to reduce staff to meet financial targets; quality versus value; pace versus perfection; and
- Time to make the changes in a considered way, building on extant initiatives like the Black Country Alliance, to enable change to made in a positive way that will be sustained and deliver long term clinical and financial sustainability rather than rushing to drive short term impacts that could unwind and cause more harm than good.

Back Office Functions

There is a broad range of back office service delivery across organisations within the Black Country and West Birmingham. The CCGs have differing levels of outsourcing already in place through Commissioning Support Units (CSUs) and other providers (particularly for payroll), alongside in-house provision; and Providers and Local Authorities largely have their services delivered by in-house teams and, in some cases, themselves deliver services to other organisations.

It is recognised that this will primarily focus upon the health partners of the STP, although Local Authority partners are active in the discussions and may contribute to some of the solutions which may be considered. Discussions already taking place across organisations have identified enthusiasm for delivering transactional excellence, driving efficiencies and sharing best practice to enable improved resilience and reduce reliance on temporary staffing. The trusts have been transparent in indicating that the delivery model for those services is open to determination, and are similarly clear that the journey of improvement and any new collaborative delivery model – in-source, joint-venture or out-source - has to start with resolving and aligning extant processes, procedures and their underpinning systems. Out-sourcing a problem will simply add to costs. Rushing to consolidate may simply incur transactional costs and raise concerns among those impacted without having a clear route to value.

By working at scale across the STP, there is significant potential to integrate the non-clinical support services across both provider and commissioner organisations. Building on the early work of the Black Country Alliance (BCA), we will review key back office functions to verify the level of efficiency that is achievable. We believe (supported by the Carter Review and the experience of CIP schemes in individual local organisations) that there is greatest potential in the following areas:

- Payroll services
- Support Staff employment models
- Procurement, Human Resources (HR), telephony and legal services
- Common call centres
- Licensing of telephones, IT applications etc.
- Hotel services.

Our ambition is to move swiftly to identify which services may benefit from further collaboration, including an assessment of which service may be consolidated in 2016/17. In April 2016 the BCA Board established a comprehensive programme of work covering all back office functions across the three trusts. We are now devising a broader STP programme plan for services in 2016/17 and over the coming years (as some services are already under contract terms).

We have agreed the following principles:

- The efficiency we need by 2019 goes beyond what any part of the STP currently delivers, simply being among the current best is not good enough;
- Aggregation is not guaranteed to drive value - to get 'value' we know we need to know what we want and we will use a variant of our triple aim to guide us;
- Local employment matters and pay rates matter, we are not simply seeking the lowest possible cost model or we would, typically, outsource abroad;
- We recognise the potential to work towards a single 'virtual organisation' should the evidence support that but, first, we aim to build more securely on existing partnerships whilst keeping under review the opportunity for further consolidation;
- We approach this with a view to exploring closely the benefit of having strategic leadership across some of our functions, and in terms of opportunity to share transactional services. However, we are also mindful of the transactional costs associated with transitioning to shared service models, and the risks of impacting outcomes & experience of the service through disruption;

- We believe local business partnering and presence will continue to be a feature of most services; and
- We will seek where possible to ensure all organisations have an opportunity in this area, which enables broader engagement, capacity and will to take the work forward.

The first six-month wave of projects, mobilised in April, is reviewing potential for collaboration on a range of HR enabling processes including our use of Electronic Staff Records (ESR). We plan to reduce agency spend by working together on temporary staffing and administration, moving toward consistent admin, systems, processes and rates to establish a Black Country and West Birmingham Bank which will we think significantly reduce Agency spend. We are reviewing Clinical Coding, Information Governance, Legal Services, Research Governance, Contract Management and Procurement. Second phase will begin in October and will cover energy procurement, complaints handling, medical illustration / communication, emergency planning, mandatory training, disciplinary and conduct investigations, debtors and claims, safeguarding and recruitment.

As we mobilise a broader STP-wide programme to explore options, we will consider the merits of various delivery models, but will continue to focus in function rather form as we do so. Forms we may assess include but are not limited to:

- Use of CSUs to deliver across both CCGs and Providers
- Creation of an entity owned by the NHS bodies to deliver services to all partners
- Use of multiple providers to deliver services to NHS bodies

The quality and operational benefits will be assessed over the coming months but the following benefits are expected:

- Consistently high quality levels of service and improved resilience for those services, reducing the demand for temporary staff.
- Standardisation of service leading to fewer errors and improved efficiencies associated with fewer systems and economies of scale.
- Opportunities for more specialised level of service to be financial viable across a wider range of bodies
- Standardised ledger will lead to efficiencies in organisations, e.g. annual accounts process
- Potential for improved career opportunities for staff working in larger functions.

In advancing these plans, we are mindful of a range of issues and risks:

- Existing contract arrangements may be an impediment or delaying factor. CCGs in particular have recently entered into contracts with CSU providers. Consolidation may require termination payments, degrading the value for money case;

- In order to minimise risks of service disruption, a phased approach will need to be developed. Potential for consolidation may have adverse impact on morale that may lead to deterioration in service levels;

- Transactional costs associated with moving to consolidated models, dual running costs associated with changing service delivery models and the opportunity cost associated with distracting resources from other priorities will make the value case for change harder to make, and resulting in long period of pay back or inability to fund the change.

These risks would benefit from the same mitigations proposed in relation to clinical support services.

Midland Metropolitan Hospital Development

This project develops a new acute hospital and A&E department, merging two District General Hospitals into one – with associated community infrastructure – by October 2018.

Existing acute services are not sustainable: 60% of ED consultant roles remain vacant, and 50% of SWBH acute physicians; and Two-site services are not able to meet Keogh standards. Half of the Unitary Payment for the new hospital will be met through single-site efficiencies in staffing, including rotas. The Trust will be able to eliminate much of its medical agency bill which is one of the highest in a metropolitan area in the country. Acute bed capacity in the STP will then be within a range of 2.0-2.75 per 1,000 resident population. According to the NHS Confederation[2], the UK has 2.8 hospital beds per 1,000 people in 2013, compared to 8.3 in Germany, 6.3 in France, 3.1 in Denmark, 3.0 in Spain and 2.8 in New Zealand. Key to succeeding will be flexible capacity in intermediate care through existing arrangements and through our work on nursing home provision.

Capital investment will be required for additional ED attendances expected following the catchment changes of Walsall when MMH opens. The capital, which forms part of the Trust's investment planning, will be required to upgrade ED facilities on the Manor site together with additional inpatient facilities.

Commissioning for Quality in Care Homes

We have identified a number of opportunities for improving the commissioning of care home services across the Black Country and West Birmingham.

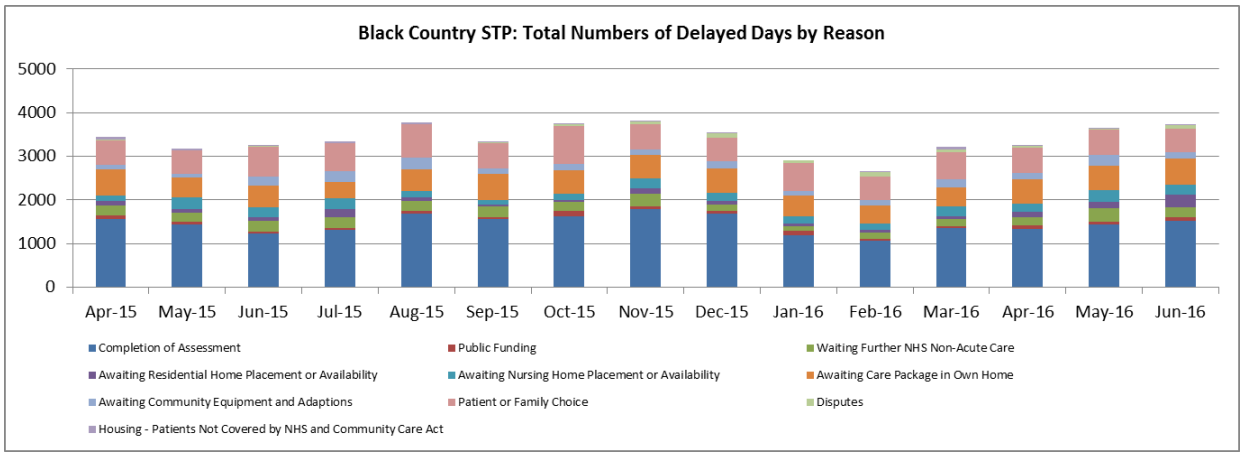
In their role as lead commissioner, Local Authorities will work with CCGs to explore how commissioning, such as enhancing primary care, can enhance the quality of services. This will

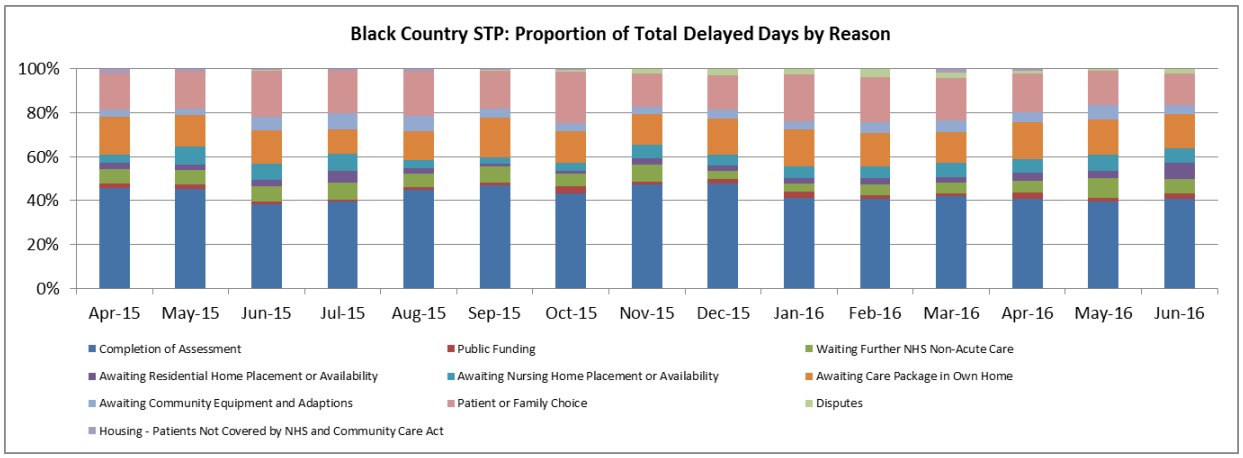
[2] http://www.nhsconfed.org/resources/key-statistics-on-the-nhs

build on work initiated by the West Midlands Association of Directors of Adult Social Services (ADASS) which is completing a region-wide analysis of residential and nursing home provision. The WM ADASS has undertaken a West Midlands-wide analysis of residential and nursing home provision. Data analysis can be made available on an STP-footprint and will be commercially sensitive. Councils already have responsibility for market-shaping and a workstream is underway. This will help us improve our health and social care system.

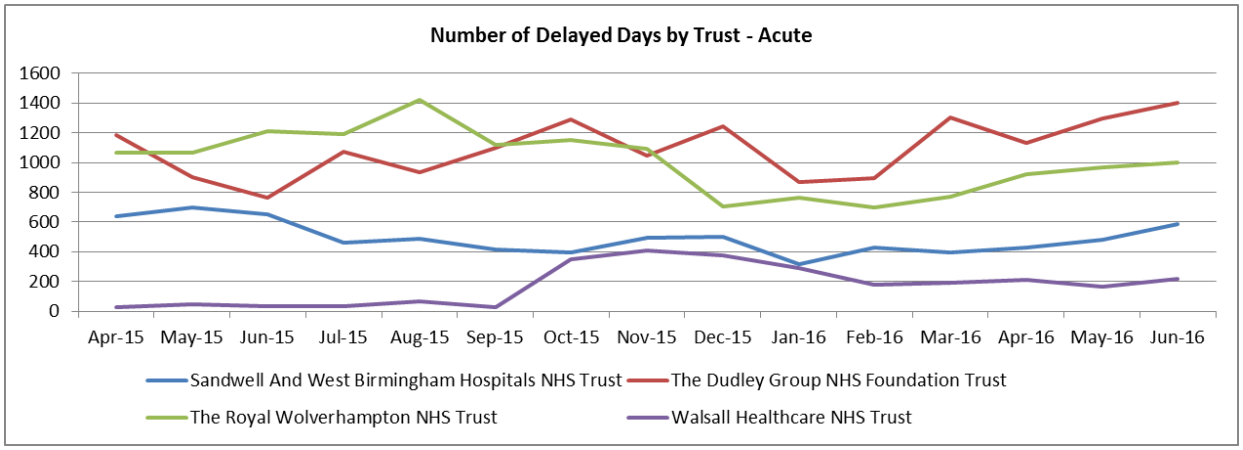
This will cover a wide range of care and support that adult social care commissions, such as residential and nursing care, care in the home, personal assistants, day opportunities, and more. It is important that, as care and health commissioners work closer together through this plan, we understand the impact of commissions on the market place so that we are moderating the costs of care across the boundaries of health and care, and across geographical areas. At present each commissioner will pay differential rates for the types of "placements" that they purchase. We can maximise the ability of new opportunities to commission and procure together for the best outcomes for people and for the value of the public purse.

There are also opportunities to reduce delayed transfers of care (DTOCs) from acute settings through improvement in the provision of care home services. The following tables summarise the causes of these delays:





An analysis by acute provider demonstrates variation across the STP:



In addition, we have modelled the potential for reducing spells and costs for Black Country and West Birmingham Patients aged 65+ who are in receipt of packages of care (residential or nursing home plus CHC services). By extrapolating detailed analysis undertaken for Dudley CCG across the Black Country and West Birmingham, we estimate that standardising models of care in relation to care packages could save around 3,000 spells and £7m p.a. (acknowledging the likelihood of double counting across areas of care).

Estimated Avoidable Activity and Costs	Spells	Cost
Readmissions within 30 days of discharge	660	£1,851,240
Falls related	660	£1,628,790
Frail Elderly - Usually managed elsewhere	544	£1,192,482
Ambulatory Care Sensitive - Vaccine Preventable Conditions	218	£699,049
Frail Elderly - Occasionally managed elsewhere	232	£655,449
Ambulatory Care Sensitive - Chronic Conditions	251	£593,175
End of Life Care long	104	£348,880
Ambulatory Care Sensitive - Acute Conditions	99	£209,548
End of Life Care short	101	£187,308
Zero length of stay, no procedure, discharged alive - adults	344	£174,036
Medicines related	55	£133,893
Medically unexplained symptoms	58	£69,355
TOTAL	**3,324**	**£7,743,205**

The main key to improving care home provision lies in the re-design and enhancement of community-based provision. This model can be complemented by effectively improved services across a continuum from re-ablement, 'step down' and care home services. Effective commissioning of community-based services is a first principle which needs to underpin the approach to use of care homes.

Effective Delivery of Cost Improvement Programmes

In order to deliver the existing Cost Improvement Programmes of our organisations (including Carter efficiencies, LOS reductions, and workforce re-design), we have agreed a set of key actions;

- Ensure PMO arrangements within Trusts are robustly supported;
- Align extant CIP plans with emerging QIPP delivery plans to re-confirm no double-count positions;
- Ensure STP programme office familiar with local schemes to avoid risk of re-counting planned local supply side efficiencies; and
- Track demand side efficiencies to ensure income impact is matched by real costs change.

Three quarters of our hospital-linked providers delivered surplus plans in 2015-16. Each has a CIP programme for 2016-17 of 2-4.5% for coming years, and has agreed STF financial control totals. Explicitly co-operating at scale will deliver added savings value beyond changes in organisational form.

We plan to:

- Scope a commercial offer to GP practices and other 3rd parties
- Explore NEWCO employment models
- Contract out provision through bulk STP-wide opportunities
- Model benefits of merging call centre functions (including LA on-call)
- Software licence definitions and license pooling opportunities
- Mobile phone & pager contracts
- Examine the distribution, cost profile and funding of hotel services; opportunities for joint sourcing or supervisory opportunities; and benefits of single pan-Black Country and West Birmingham provider etc.

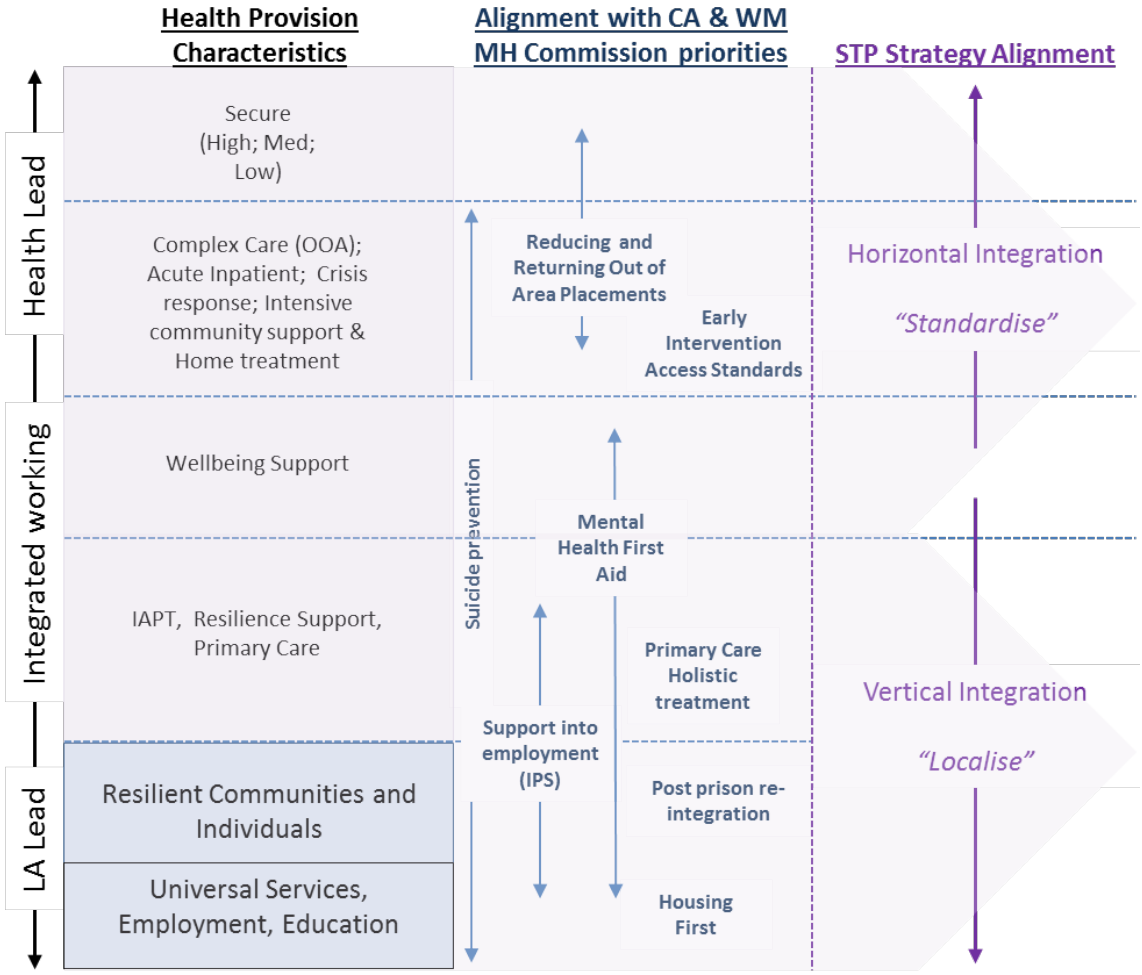
Improving Mental Health and Services for Learning Disabilities

Become One Commissioner

Our CCGs propose to operate as 'one commissioner' across the Black Country and West Birmingham, leading to a substantial reduction in the current unwarranted variations in the quality of care, standardised services, and the creation of an environment in which our providers can maximise resources and workforce through better skill mix utilisation. This will build on the Transforming Care Together (TCT) partnership vision to create synergies and improve the experience of Black Country and West Birmingham residents affected by Mental Health and Learning Disabilities (MHLD). By sharing best practice *and* aligning to the work of other agencies we will reduce variation; improve access, choice, quality and efficiency; and collaborate to develop new highly specialised services in the Black Country and West Birmingham (e.g. Children's Tier 4, secure services and personality disorder services).

By agreeing common specifications and models we will develop standardised and potentially more cost effective solutions, and minimise service variation, including putting in place a recovery model that supports people to avoid crisis and manage their own care as much as possible, whilst supporting them at times of need. This will reduce role duplication, streamline service management and allow investment in front line staff development and up-skilling. Additionally, there are opportunities to develop this across the West Midlands through the work in the MERIT vanguard (Mental Health Alliance for Excellence, Resilience, Innovation and Training). Overall, this approach to harmonization and standardisation will:

- Simplify access to services improving health and wellbeing for users, families, staff and communities;
- Put in place common, responsive and standardised all age Early Intervention services;
- Combat variation in care and service delivery across the Black Country and West Birmingham;
- Ensure clear, simplified pathways for users, ensuring most effective use of resources;
- Achieve economies of scale for providers and reduction of duplication; and
- Improve utilisation in front line services through better skill mix usage and reduction in temporary and locum costs.



Principles

Parity of esteem for mental and physical health
Collaboration/partnership
Co-production
Standardisation of core specifications: single model/pathway/specification: specialized and acute services
Locally designed community services based on a core model/pathway
Evidence based commissioning
Maximise resource use: financial/workforce/estate

Build the Right Support for Learning Disabilities

The Black Country and West Birmingham Transforming Care Partnership (TCP) is a partnership of local authorities, CCGs and NHSE (Specialised Commissioning) working together to deliver the vision set out in Building the Right Support and the National Service Model. The partnership enables the TCP to build on existing collaborative commissioning arrangements, facilitate improved local health economies of services for people with a learning disability and/or autism, and to commission at sufficient scale to manage risk, develop commissioning expertise and commission strategically for relatively small numbers of people whose packages of care can be very expensive and difficult to procure and monitor in isolation.

We aim to deliver 'Building the Right Support' (the National Plan) across the STP footprint, to reduce reliance on inpatient care by 62% within 3 years, to improve quality of outcomes for people with learning disabilities and/or autism through the development of standardised outcome measures, care pathways and clinical services.

To date, as part of meeting the vision of TCP, ten inpatient beds have been decommissioned, with consultation currently taking place regarding the proposed closure of one Assessment and Treatment hospital; dependence on inpatient services has reduced by thirteen 13 beds (12%) across CCG and NHSE commissioned beds over the last six months; an Intensive Support Service has been commissioned as a pilot in Wolverhampton (2016) with a view to sharing learning across the footprint (January 2017); and revenue funding has been awarded from NHSE (£380,000).

Improve Bed Utilisation and Stop Out of Area Treatments

Inpatient provision is a key part of the whole system in support of people's mental health and wellbeing. It is resource heavy, but is only appropriate for a minority of people in contact with mental health services. Our ambition is to ensure that patients receive hospital care only when their health needs require it by commissioning appropriate consistent crisis services across the Black Country and West Birmingham. When admission is required it is (where possible) within the Black Country and West Birmingham ensuring that links are maintained with local support networks. We will determine the optimum bed requirement for existing services provided by NHS providers, which should support development of new highly specialised services.

We aim to retain Black Country and West Birmingham funding in the STP to deliver the right care in the right place for service users, working across current NHS providers, ensuring the right capacity of beds to meet the demand (numbers and service type). Although bed day costs are unlikely to deliver savings, efficiency should be delivered through reduced length of stay from strong local partnerships with social care, housing and family. This should reduce cost for Commissioners through existing out of area placements (savings only for services that can be provided from existing skilled staff). It will improve sustainability to existing providers by improved utilisation and profitability of inpatient units.

Deliver the West Midlands' Combined Authority Mental Health Challenges

Mental Health is an important issue nationally and in the Black Country and West Birmingham. The level of employment for individuals with mental health issues is significantly lower than the employment rate in the population.

In the Black Country and West Birmingham, the rate of employment for people with mental health issues is lower than the national average, and is particularly low in Wolverhampton.

Assuming the Black Country and West Birmingham could achieve the employment rate for people with mental health issues achieved in England (adjusted for the overall lower employment rate in the Black Country and West Birmingham) then an additional 4,000

people with mental health issues would be in employment in the Black Country and West Birmingham. At average full-time employment wage rates in the Black Country and West Birmingham, this would equate to an additional £100m of income less reductions in benefits.

Employment of individuals with mental health conditions, 2015[3]

	Number of people with mental health issues employed	Employment rate for people with mental health issues	Employment rate for whole population
Dudley	4,000	23.3%	69.5%
Sandwell	5,900	39.5%	70.2%
Walsall	4,200	28.2%	63.0%
Wolverhampton	2,600	21.7%	66.3%
Black Country	16,700	28.3%	67.5%
England	1,088,433	39.1%	74.2%

Labour Force Survey, Taken from the HSCIC indicator portal

Data is available for the number of people claiming Disability Living Allowance (DLA). This is presented below and shows that the percentage of the population claiming DLA in the Black Country and West Birmingham is similar to the national average. Using an average DLA payment of nearly £75 per week, the annual payments in the Black Country and West Birmingham are estimated to be nearly £44 million.

Disability Living Allowance claimants and payments for mental health issues in the Black Country, 2015

	No. of claimants (16-64)	% of population	Weekly value of benefits (£000)	Annual value of benefits (£000)
Dudley	2,615	1.4%	196	10,172
Sandwell	3,358	1.7%	251	13,060
Walsall	2,633	1.6%	197	10,240
Wolverhampton	2,618	1.6%	196	10,181
Black Country	11,223	1.6%	839	43,653
England	550,760	1.6%	41,199	2,142,333

ONS mid-year population estimates, DWP benefits claimant data

[3] This uses quarterly data. Data for 2015 Q2 was unavailable for Walsall and Wolverhampton, therefore the 2015 average is an average of Q1, Q3 and Q4 for all areas

Research suggests that employment and work is beneficial to mental health (Waddell and Burton, 2006). This improvement in health has a positive impact on the health service (as patients require fewer treatments) and can also help to move people off welfare payments, which is beneficial to the Government. If more people with mental health can return to employment then it will also improve the productive capacity of the Black Country and West Birmingham area.

The West Midlands Combined Authorities Mental Health Commission, chaired by Norman Lamb, has identified a series of 'Health delivered' interventions for the Combined Authority's regeneration programme. Just as economic success underpins Mental Health, good Mental Health ensures employability and underpins regeneration. For the programme to be successful, the strong relationship between these drivers needs to have firm foundations, working collaboratively across the Health and Local Authority Commissioning and Provisioning organisations.

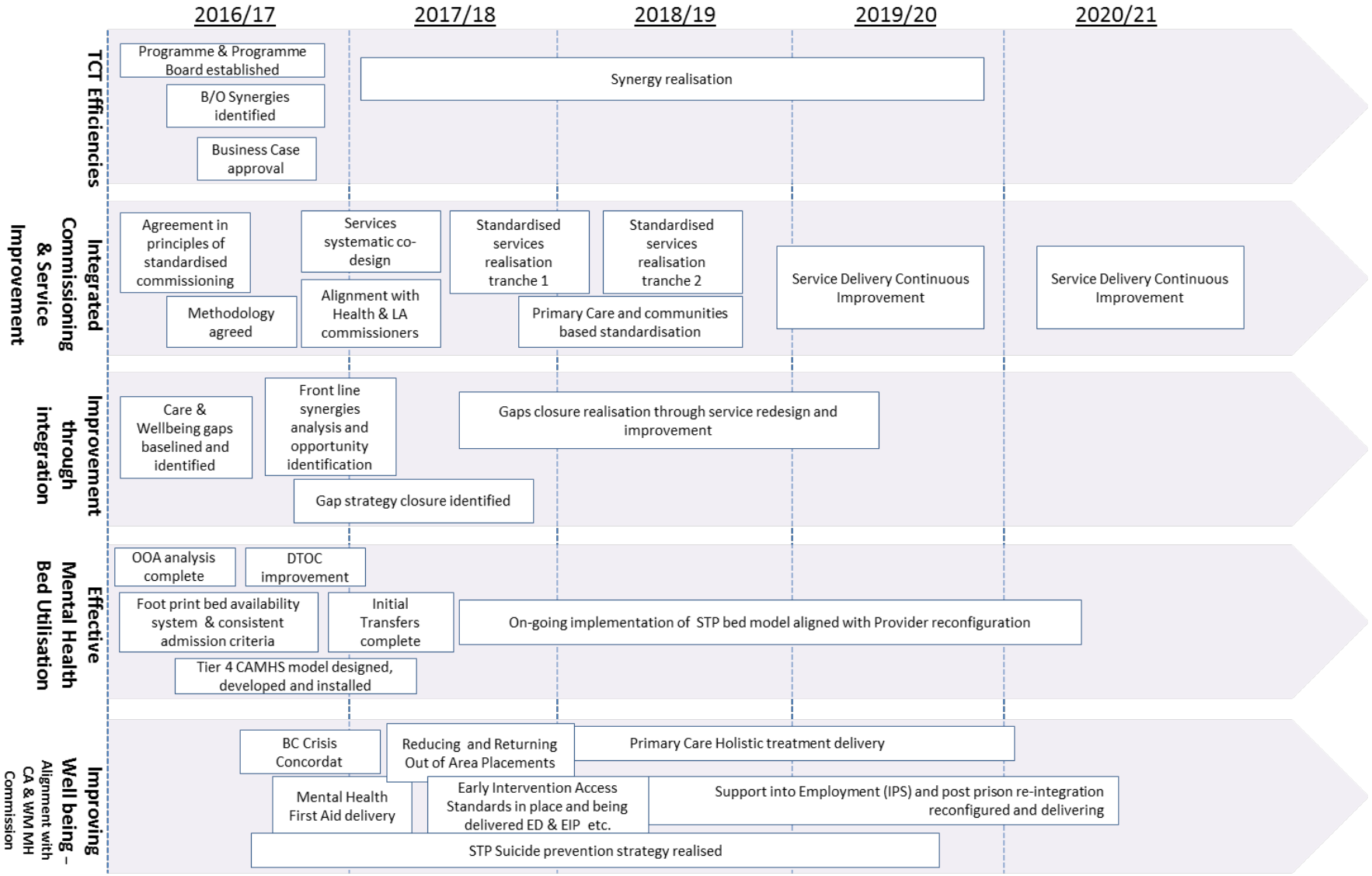
Deliver Extended Efficiencies through Transforming Care Together Partnership

Our vision for the Transforming Care Together (TCT) partnership is based on harnessing the strengths of three high performing NHS organisations, with uniquely aligned services (mental health, learning disability and children & families), to create synergies that will benefit our communities, our staff and our stakeholders. This specific opportunity will focus on harnessing efficiencies, best practice and sustainability by streamlining corporate and back-office services and infrastructure (IT and estates in particular).

By combining our corporate and back office functions, we hope to achieve significant efficiencies to support our future plans for clinical service transformation. The rationale is based around achieving economies of scale, reducing duplication, better management of pan-partnership roles and harmonising of policies and procedures.

Our overall delivery plan for Mental Health and Learning Disability Services is shown overleaf. It will be supported by £10m in capital investment to enable the changes to our estates required for service transformation.

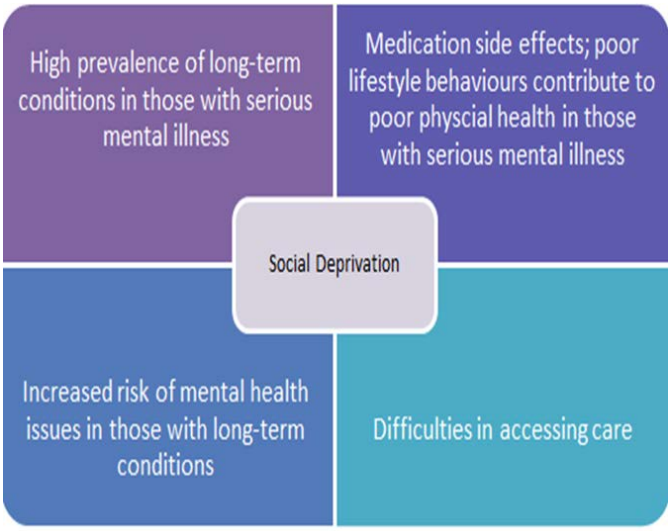
MH STP Delivery Timeline



Identifying and Addressing the Physical Health Needs of Mental Health Service Users

In addition to our established Mental Health and Learning Disability projects, the STP has commissioned analysis of how mental health service users' experience of physical healthcare services may vary from that of the rest of the population. That analysis is summarised below and we now aim to work with partners (service users, carers, and the West Midlands Combined Authority) to identify how best to respond to the challenges identified.

The health outcomes of individuals with mental health problems often fall short of the outcomes of the background population. Furthermore there is evidence that mental health service users present at acute hospitals in times of crisis. There are a number of factors that help to explain this:



In 2011 the Government launched its mental health strategy, *No Health Without Mental Health* (HM G, 2011) setting out its vision for mental health services to deliver on par with those for physical health. Building on this strategy the Mental Health Taskforce developed *The Five Year Forward View for Mental Health* (NHS England, 2016) which identified three key priorities;

- A 7 day NHS – right care, right time, right quality
- An integrated mental health and physical health approach
- Promoting good mental health and preventing poor mental health

New analysis commissioned by our STP from the Strategy Unit has found the following:

- The life expectancy of men in contact with mental health services in the Black Country and West Birmingham is 17 years lower than the rest of the male population. For women the gap is 14 years. This life expectancy gap, consistent with other international studies, is long standing and has closed only marginally since 2006.
- Mental health service users experience higher mortality rates across all major disease groups. Whereas cancer is the leading cause of death for the population as a whole, circulatory disease is the most common cause of death for mental health service users.
- Approximately 1 in 5 of all A&E attendances and emergency admissions relate to mental health service users whose A&E attendances and emergency hospital admission rates are three times those of the rest of the population.

- Outpatient DNA rates run at almost 15% for mental health service users; considerably higher than other patients and rates of diagnostic imaging are almost twice as high among mental health service users as the rest of the population.

The analysis also identifies opportunities for improving care for mental health service users:

- The STP could save up to £1.9m in A&E attendances and up to £17.7m in inpatient care, by reducing mental health patients' hospital activity, in subgroups which may be amenable to commissioner based QIPP schemes, to the same levels as the rest of the population. In practice, reducing acute healthcare utilisation of mental health service users to that of the rest of the population may not be wholly attainable, and clinical advice will be required concerning what is realistically achievable for each condition.

- Compared to England, the STP overall has higher utilisation for many of the opportunity subgroups. Patients conveyed by ambulance to A&E but discharged following no investigation and no treatment, frequent A&E attenders and patients admitted for self-harm are the exceptions to this.

- The overall mental health cohort had higher utilisation for each opportunity than the non mental health cohort. Almost without exception, those with cognitive impairment have the highest relative use of acute services of all mental health patients for all sub-groups of activity.

- The largest single potential saving (£16.7m) for the Black Country and West Birmingham is estimated to come from reducing admissions for those attending A&E with a primary diagnosis of mental health. The extension of psychiatric liaison services may impact on multiple opportunities – e.g. reducing admissions for mental health issues, self-harm and medicines adherence.

- These potentially avoidable hospital admissions represent an opportunity cost. Targeted investment in evidence-based interventions could release acute hospital costs whilst improving the physical health of mental health service users.

The following developments could help us to grasp these opportunities for users of mental health services, working in partnership with service users and carers:

- Mental health services could enhance annual health checks and make them effective as part of the individuals overall health care plan, review all prescribed medication for toxicity and side effects, work with partners to very significantly increase health improvement /risk reduction interventions (e.g. exercise on prescription, use of third sector community building opportunities) and staff in mental health services could develop a better understanding of physical health needs.

- Liaison and joint working between mental health and acute services could be strengthened (would a mental health service know if a services user had presented four times in the last week at A&E, and what would the mental health and the acute service do jointly about it?). Joint work between care homes, social care, voluntary services, mental and physical health could also be beneficial.

- Psychiatric liaison services are developing across the country but the outcomes achieved (and resource used) could be reviewed. For example, are integrated models for jointly managing the mental and physical implications of long term conditions and medically unexplained symptoms being developed?

- To enable an outcomes based approach to be implemented, there will need to be co-production of service models and feedback loops involving staff, users and carers. This could not only add knowledge and understanding but also make a real difference to the duration and quality of the lives of many Black Country and West Birmingham people.

- Local arrangements for integrating primary and community services on a place basis should always include mental health, social care and voluntary services. This represents the ideal opportunity to consider how this integrated team can develop innovative, locally sensitive options to address the physical health needs of their population in receipt of mental health services.

Getting the Best Start - Improving Maternal and Infant Health

The infant mortality rate in the Black Country and West Birmingham is much higher than the national average. Only Dudley has a rate lower than the national average, while the other local authorities in the Black Country and West Birmingham have a higher rate than the national average.

Annual infant mortality in the Black Country, 2011-13

	Number of infant mortalities per year	Infant mortality rate (deaths per 1,000 live births)	Best rate in England
Dudley	14	3.7	1.1
Sandwell	34	6.9	1.1
Walsall	26	6.8	1.1
Wolverhampton	24	6.8	1.1
Black Country	98	6.1	1.1
England	2,729	4.0	1.1

Public Health England Health profiles 2015, ONS Birth Summary tables

There are high levels of deprivation, teenage conceptions and smoking at the time of delivery which contribute towards some of the poor maternal, infant and child outcomes. A coordinated maternity pathway alongside the provision of universal and targeted support will improve the quality of maternity care and prevent lifelong disability arising from poor outcomes at birth. In addition, if the infant mortality rate in the Black Country and West Birmingham can be reduced, this will provide an economic benefit to the Black Country and West Birmingham (through productive capacity in the future) and to society (the human costs of the Value of a Statistical Life).

Value of a Statistical Life, WebTAG

Element	Value (£000)
Productivity	591
Human Cost	1,126
Medical services	1
Total	**1,718**

Department for Transport, WebTAG databook, 2016; HM Treasury, GDP deflators

A reduction in Black Country and West Birmingham infant mortality rates to those achieved in England would deliver 34 fewer deaths, and an economic saving of £58m. However, improving infant mortality rates is also likely to have a positive impact on the number of children born with serious health conditions (through better screening and treatment of pregnant women and new-born children). The total economic saving from these measures is likely to be higher therefore.

We aim to improve maternity care and infant health outcomes across the Black Country and West Birmingham through the development of standardised pathways of care and quality improvement, involving:

- Implementing the recommendations of the Cumberledge report including improved cross boundary working and post/perinatal mental health services across the Black Country and West Birmingham;
- Public Health departments working together to provide evidence based recommendations of effective interventions to improve outcomes and to develop an STP-wide network for sharing intelligence and best practice on maternal, neonatal and infant health;
- Local and strategic partners developing a Black Country and West Birmingham Healthy preconception and pregnancy pathway that addresses risk factors associated with poor maternal, infant and child health outcomes; delivers integrated maternal and neonatal health services, providing accessible care tailored to needs; improves the quality of care provision via Maternal and Neonatal networks reducing variation and standardising best practice; and ensures multi professional working and learning across frontline professionals caring for women and their babies;
- Identify opportunities for system wide action on the wider determinants of health; and
- Model maternity capacity projections across the Black Country and West Birmingham and develop options for delivery.

To support the review of maternity services across the Black Country and West Birmingham, we have commissioned the Strategy Unit to develop, in partnership with neighbouring STPs, local estimates for the volume and type of inpatient birth episodes, maternal bed days and associated costs that might be expected in future. This work is due to complete by the end of Q1 2017/18.

The outcome of the West Midlands Neonatal Review has identified that capacity and demand is mismatched between maternity and neonatal services. Alongside the STP, NHS England specialised service commissioners will rebalance capacity across the footprint which is likely to lead to changes in capability and capacity within a number of units.

Three key themes have been identified:

- Infant mortality (health gap)
    - Defining a set of agreed metrics to support improved performance outcomes
    - Maternal mental health pathway
- A sustainable model for maternity and neonatal services (sustainability gap)
    - Effective pre-conception care
    - Healthy pregnancy pathway
    - Neo-natal pathway
    - Normalisation agenda for delivery
- National Better Birth agenda (quality of care gap)
    - Sustainable options for future delivery of standardised care
    - Reflective of national direction - Better Births: access, choice and empowerment.

Addressing the Wider Determinants of Health

We will build on existing partnerships with individual Local Authorities and the West Midlands Combined Authority to support the delivery of appropriate Local Authority efficiencies (the plan assumes application of the Social Care Precept and of the net Better Care Fund increase), to take effective action together on prevention and the wider determinants of health, to maximise the impact of health spending in the Black Country and West Birmingham and, as set out above, to implement the recommendations of the Mental Health Commission. The STP Plus agenda agreed by WMCA covers:

- The Mental Health Commission (see Improving Mental Health section)
- Best Start in Life (see Maternal and Infant Health section)
- One Public Estate (see Key Enablers – Infrastructure section)
- Place Based Regulation (see Future Commissioning section).

Reducing the Prevalence of Long Term Conditions

The healthy life expectancy of residents across the Black Country and West Birmingham is generally lower than the England average, indicating a considerable number of years is spent living with disability resulting from long term health conditions (LTCs). Care of people with LTCs accounts for 70% of the money spent on health and social care in England. Population projections predict an increase in residents over the age of 75 years across the Black Country and West Birmingham, with longer life expectancy but a high likelihood of increasing demand for health and social care services within this, and younger, population groups. Poor health outcomes are the result of lifestyle choices such as smoking, alcohol misuse and unhealthy eating, which significantly contribute to the development of LTCs. The prevalence of LTCs can be reduced by focusing on primary prevention to halt the occurrence of LTCs and extend healthy life expectancy by addressing lifestyle factors. Secondary prevention will support optimal management of LTCs, slow disease progression and reduce the demand for services.

We aim to improve the healthy life expectancy of Black Country and West Birmingham residents by achieving a significant reduction in the prevalence of long term conditions (LTC) through promotion of the prevention agenda and building resilient communities. Public Health departments will work together to:

- Provide evidence based recommendations to support the prevention agenda; and
- Develop an STP-wide network of best practice and identify prevention resources & self-help tools.

Local partners will work together to:

- Deliver ambitious programmes across the Black Country and West Birmingham to address key lifestyle risk factors, mobilising health and social care systems to deliver Making Every Contact Count. This will include promotion of workplace health initiatives across health, social care and local business;
- Support the development of social capital to address social isolation and improve resilience, enhancing local knowledge of community resources and support whilst creating a culture where communities and groups can themselves identify gaps and develop solutions for local people;
- Promote independence through personalisation;
- Develop place-based models of care to improve management of LTC;
- Improve employability and skills development; and
- Encourage a wellbeing focus across all health and social care policies, planning and departments.

Maximizing the Impact of the Health Pound

One of the major drivers of the financial gap in the Black Country STP is projected increases in demands for health and care over the planning period. There is a clear evidence base to demonstrate that the wider determinants of health and wellbeing lie mainly outside of the health and care system and relate to employment, wealth, education and housing.

Our STP commissioned a unique economic study through the Strategy Unit and ICF International in order to provide:

- An indicative assessment of the economic impacts in the Black Country and West Birmingham, that flow from spending by the NHS on health services
- A framework for assessing the wider impacts of changes in the scale and/or type of health services spending.

The study tracks healthcare expenditure and the subsequent effects on the demand for goods and services (through procurement) and for labour (skills and wages). The economic impacts associated with treating the population, especially, the working age population, with subsequent effects on levels of labour market output and productivity, have also be added. In both cases the focus is on the patients, health sector workforce and procurement located in the Black Country and West Birmingham. There is also brief analysis of services that have the potential to have significant economic impacts; informal care, infant care / mortality and mental health services. The more effective healthcare services are, the greater the economic as well as health benefits. The analysis seeks to distinguish between patients according to age and economic activity. The study has aimed to:

- Quantify the health and wellbeing benefit of the economic redevelopment proposals associated with the Combined Authority's proposals;
- Address through the Combined Authority the wider determinants of health including employment, housing, welfare and education; and
- Identify the contribution that the STP plan can make to the Combined Authority's goals through reduced welfare dependency, employment and procurement, recognising health as a major industry sector in the West Midlands.

Key findings to date include:

The NHS spends some £2 billion in the Black Country and West Birmingham each year.
The additional income (Gross Value Added) as a result of this NHS expenditure is £1 billion each year. This represents 5.5% of the GVA of the sub-region (representing £1 in every £17).
The multiplier effect of NHS spending (when NHS staff and suppliers spend money in the Black Country and West Birmingham) is estimated to be 1.43, increasing the total NHS-generated GVA to £1.53 billion.
The value of informal care undertaken by some 16% of the Black Country and West Birmingham population is estimated at a further £2 billion each year. The majority of carers provide between one and nineteen hours of care per week, rising to fifty hours for the economically inactive.
The Black Country and West Birmingham operates a small export surplus on NHS services with more non-Black Country residents treated in the Black Country and West Birmingham than local residents treated outside the area.
The NHS in the Black Country and West Birmingham also spends £1 billion on the purchase of goods and services, some supplied by local businesses.
The NHS is the largest single employer in the Black Country and West Birmingham. NHS expenditure supported 30,800 full-time equivalent (FTE) jobs in 2015, of which 24,000 FTE jobs (and some 29,000 people) were directly employed by the NHS. This represents 6.3% of total employment in the sub-region (1 job in every 14). Additional employment of 10,000 FTE jobs results from NHS spending on goods and services.
The NHS workforce is highly skilled, with average wages of the NHS workforce some 26% higher than the average wage for the Black Country and West Birmingham workforce.
The NHS in the Black Country and West Birmingham occupies 23 acute (hospital) sites, covering 125 hectares and over 511 million square metres of floorspace, with a notional land value of £188m. GP practices in the Black Country and West Birmingham were estimated to occupy 61 hectares of land, with an estimated value of £70 million.

Other work undertaken local to examine the economic impact of social care has found the following:

- Based on work undertaken in the City of Wolverhampton, the economic value of adult social care alone in the Black Country STP area is over £1 billion a year based on direct and indirect spend;
- Each locality's Director of Adult Social Services is accountable for the quality of the whole commissioned workforce in their area and there are approximately 30,000 staff in paid care roles working with adults in the Black Country STP area; and
- No calculation currently exists for the local or regional economic contribution of services supporting children, young people and their families but the economic value of social care services more broadly could be as high as £2 billion.

The second phase of the NHS study begins in November when the STP will seek to identify opportunities through which NHS spending could be used to further enhance the associated economic impact.

The following table identifies possible areas for discussion:

	Current activity	Discussion
Recruitment	With a direct workforce of over 24,000 the NHS is the largest employer and recruiter of labour in the BC. It is also one of the most skilled.	How can this recruitment activity be leveraged in support of wider recruitment plans? For example, offering incentives to the spouses of NHS applicants currently resident outside the sub-region
Training	Significant investment is made in the training of NHS staff, one of the largest training programmes in the BC	The training offered to the local NHS workforce, whilst specific to NHS occupations, offers a well-developed training infrastructure. How could this infrastructure be utilised for other employers, especially in the area of transferable skills?
Improved services to reduce the need for unpaid care	12% of those in employment provide some level of unpaid care, with an opportunity cost based on the value of (leisure) time of £0.6 billion each year	Providing informal care services has potential costs to carers in employment and employers. One possible option could be to mobilise the voluntary sector to take on some of this care. Is this feasible and what other options are available?
Adjustment to out-patient services	Half a million hospital out-patients from the local working population receive treatments each year	Even small reductions in the time taken off-work could have significant cost savings to local employers / employees. Transferring some out-patient treatments to primary care might be one approach, is this possible and what other options are available?

	Current activity	Discussion
Procurement	Over a £1 billion is spent each year. Much of this on employment services, pharmaceuticals and IT systems, but a wide range of goods and services are procured	The need for transparency and economies in procurement prevent any positive discrimination in favour of local firms. However, assistance for local firms to participate in NHS procurement procedures could be considered. How might this be achieved?
NHS estate management	The NHS occupies 125 hectares of land in the sub-region, with over 500 million m2 of floorspace. GP practices occupy (but do not necessarily own) some 60 hectares of land	NHS sites tend to be highly accessible and have limited development constraints compared to available development sites. Are there any opportunities for improving NHS services through reorganisation of the NHS estate, including sale/lease and relocation to non-NHS sites, and improving the supply of development land?
NHS resource management	Of total purchases (£1bn in the BC) 3% (£30m) is spent on energy, and 4% (£40m) on waste management and repair services Based on national figures half of purchases (£500m in the BC) are made on goods, mainly pharmaceuticals and computer equipment, but also including a wide range of other goods.	Given the scale of spending, there is the possibility of substantial savings from improved resource efficiency. Social benefits might also be realised from the recycling of pharmaceuticals, and the reuse of unwanted computer equipment. How can these opportunities be identified and what support can be provided to the NHS to realise benefits?

Key Enablers

Workforce

Aim

Our aim is to ensure that we provide the workforce, now and in the future, that can ensure patients receive safe, sustainable, high quality care in the right place and at the right time. This will require us to be bolder and braver than before about how our workforce is shaped, provided and developed.

We want the Black Country and West Birmingham to be a great place to work and grow, with workforce transformation a core element of service transformation. New skills will be developed alongside new types of roles. We will have a reshaped workforce, working across professional boundaries, with proven competencies to ensure safety and quality of care.

A key driver for our staff will be providing a shift from treatment to prevention, from reactive to proactive care, and to steady state rather than crisis care. This will reduce the cost of delivering care by equipping and uplifting skills across the health and care system, moving care closer to home, and encouraging staff to move to and remain in the Black Country and West Birmingham.

Context

Delivering the Forward View: NHS planning guidance states that:

Planning by individual institutions will increasingly be supplemented with planning by place for local populations [and] *success depends on having an open, engaging and iterative process that harnesses the energy of clinicians, patients, carers, citizens, and local community partners including independent and voluntary sectors and local government.*

It is clearly evidenced that high performing organisations have integrated workforce planning. There are 5 benefits to strategic workforce planning:-

1. *Supports the budgeting process – good workforce planning, good understanding of the system needs*
2. *Supports the strategic/business planning process – it needs to be and iterative process*
3. *Identifies shortage of qualified talent to fill critical roles – good planning helps highlight talent gaps*
4. *Serves as a mechanism for identifying critical talent – improves the ability to identify and retain the most important talent*
5. *Identifies skills gaps in workforce*

We know that system workforce planning is easier said than done. However, the Black Country and West Birmingham has embraced the workforce opportunities provided by the STP. The Black Country Local Workforce Action Board (LWAB) is in place and will be the enabling mechanism. The STP has agreed that the majority of workforce efficiencies will be sought from the priorities ensuring there is no double counting or duplication of work.

The Health Education England (HEE) national data pack details a significant workforce across the Black Country and West Birmingham delivering health and care. This information does not include the unpaid workforce of carers and volunteers. The data pack reflects a Black Country and West Birmingham workforce of:

- c.30,800 FTE NHS staff including primary care
- c. 16,300 FTE social care.

Key Workforce Challenges

As we seek to better meet the needs of our patients, we also recognise that we are faced with same real challenges in terms of maintaining and developing the workforce patients need:

- We have an ageing workforce across the whole system (a significant proportion of the workforce are aged 55+ (15% in healthcare, 17% in social care, 11% in primary care);
- There are supply challenges as a result of the comprehensive spending review and also the implications of seven day services and out of hospital provision;
- There are a number of hotspot areas across the system including public health provision, social workers, adult nursing, Speech and Language Therapists, Operating Department Practitioners (ODPs), paramedics, sonographers, Primary Care both GPs and practice nursing, and the utilisation of enhanced and advanced role development across the system.
- We face financial challenges such as the delivery of the apprenticeship levy, living wage cost impact, changes in the LBR and tariff; and
- The provision of an integrated STP workforce plan requires data sharing agreements and also a common language, understanding and processing of the different “types” of workforce across the whole of the health and care services.

Workforce Strategy

Although currently in draft this strategy identifies five key strands for implementation:

1	**Engage sustainability and transformational leads to consider and implement workforce implications of system transformations**
	Within each of the transformational and sustainability plans people are the most important resource to ensure full implementation of the system change. The identification of the workforce implications, the mechanism for engagement and the full understanding of the proposed change is critical to the success of the priorities. It is the aim of the Workforce strategy to support and lead the detailed analysis of implications for each of the priorities. Early consideration of the workforce implications will ensure that the workforce enabler of transforming roles is connected into system change for programme development.
2	**Support and lead system leadership across organisational structures and professional boundaries**
	Collaboration across the whole system is the only possible and effective way to ensure better outcomes for people within a sustainable financial envelope and it is the strategy of the workforce leaders to ensure that the system will have the skills, knowledge and ability to lead, motivate, guide and support staff through the system change. The system leadership programme will work with regional and national partners across health and social care to: ➢ identify system leadership development programmes; ➢ Identify system leaders with experience of leading across boundaries; ➢ Develop system leadership skills through co-learning and a learning and reflective system of development
3	**Develop and deliver a workforce development plan across each of the sustainability and transformational programmes to achieve the aims of the priorities**
	Robust workforce data is essential in leading system change and redesign. Through detailed workforce data and intelligence across all partners will enable a full development plan for each of the transformation themes using the 5 step programme for workforce development. Workforce planning will include reviewing Skill mix, supply pipeline for future workforce and transforming roles. This will be fully supported by the agenda of the Local Workforce Advisory Board (LWAB)
4	**Ensure staff across all levels of the organisations are aware of the system changes and the reasons for change to enable positive responses to change**
	Working in full collaboration and partnership with the communications transformational programme to ensure all staff are educated, engaged and informed of the system changes and the rationale for these changes.
5	**Manage the system risk of people change management programmes to ensure sustainability programmes are delivered within timescales and ensuring continued high quality and safe patient care**
	To ensure successful implementation, staff must be identified as the most precious resource, ensuring their resilience to system change is maximised across both organisational and sector boundaries. The workforce strategy will oversee, manage and mitigate where possible the system risks of change management, providing advice, skills development and system solutions where possible.

Moving Forward

1. **A focus on bank and agency efficiency.** The HEE national data pack highlights that there is a vacancy proxy based on workforce plans submitted 2016 of 9.3%. The bank and agency (excluding locum) reflects a % of staff in post of 13% this indicates that there are some efficiencies to be made from this within the priority work stream. The Black Country Alliance (BCA) has already started to undertake work specifically around bank and agency and this will now be expanded to include other parts of the system. The group will start to look at the opportunities around consistency, negotiated fees, sharing resources and using technology to streamline the work (such as an app for bank staff to book directly on line).

2. **A focus on supply and demand challenges.** The HEE national data details student output versus organisational leavers for adult nurses reflects a -14 supply (on average the Black Country and West Birmingham has 271 leavers and the proxy value of students for the Black Country and West Birmingham is 257). The leavers' data does not include retirements which we know are significant in this particular staff group. Therefore we can conclude that the supply is not available with the commissioned education system so we do need to give careful consideration to placements, fast track routes for education, and recruitment and retention practices. Investing in training of a more readily available workforce which would support changes to team skill mix whilst maintaining safe care (e.g. Physicians' Associates, Band 4 Associate Nurses, Care Coordinators). There are also significant opportunities to continue building on the voluntary sector's contribution to effective patient care.

3. **A focus on standardisation.** We will also seek to move towards more standardised processes including recruiting and retaining staff for the Black Country and West Birmingham. Our Transformation Groups are working up the detailed workforce implications which will start to inform and develop a place based system for population system workforce plan.

4. **Utilisation of the LWAB.** The LWAB will be the driving mechanism for the workforce challenges and opportunities and will utilise the resources developed by HEE WM both via the STP offer, the transformational themes as well as connections with best practice across the health and care architecture.

To achieve this we are:

- Utilising the LWAB to lead and drive workforce development across the STP making extensive use of HEE resources;

- Using research and recognized evidence base to embed the principle that investing in developing our people will improve health outcomes, the experience of healthcare and make better use of our resources;

- Ensuring baseline data is collected from STP to inform forward planning and performance management;
- Adopting and spreading best practice across the system on managing turnover and reduction in bank/agency/locum;
- Considering the use of a single Black Country and West Birmingham Bank/Agency/Locum delivery function – to reduce costs and ensure consistency;
- Utilising the principles of the six step methodology to integrated workforce planning, we will employ a systematic and practical approach that supports the delivery of quality care, productivity and efficiency. It is both a scalable approach and joined up with social care; and
- Adopting and spreading best practice across the system.

Black Country and West Birmingham Digital Strategy

Digital enablement – both for services and for patients – is a key enabler of service transformation leading to sustainability. There is an evidence base which supports the triple aim benefits of digital initiatives.

- Person-Centred Digital Health
  Digital solutions must be 'person-centred'; based on the needs of the end user and must be able to demonstrate measurable health and/or economic benefits.
- Interoperability
  'If you're known to one of us, you're known to all of us'. Solutions must be capable of 'sharing by default' through the use of interoperability standards while at the same time respecting trust and confidentiality. Citizens and Users need to be confident that information is accurate, up to date and only shared legitimately.
- Big Data
  Used properly, Big Data leads to meaningful information and so to insight, action and results and further data. We will create this virtuous circle for our STP.
- Prevention through digital enablement
  Risk stratification to target proactive interventions; remote monitoring and telemedicine to improve adherence to treatment, manage LTC closer to home and prevent crisis; move knowledge from specialists to those responsible for care (including patients).

Our plan is to:

- Accelerate production and convergence of Local Digital Roadmaps, aligning existing plans;

- Form Black Country and West Birmingham Digital Transformation Board to lead, drive and own delivery;
- Develop Digital Delivery Plans to take us from current state (16/17) to digitally enabled state (17/18) to connected state (18/19) to integrated state (19/20);
- Accelerate and support extant plans within organisation & LDR footprints, ensure one direction, avoid duplication, minimise 'risk of regret' & maximise triple aim benefits; and
- Rapidly identify & deliver 'quick wins' such as ePrescribing, ToC (electronic correspondence), network rationalisation, and procurement efficiencies. ePrescribing alone is expected to generate annual savings of £24m, supported by an initial capital investment of £5m.

One Public Estate

The Black Country and West Birmingham has invested heavily in new capital assets over the past decade and has a variety of capital asset funding models in place, included several Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) facilities, which have comparatively high occupation costs. We see two streams of opportunity in this cost area. Firstly, there may be opportunity to leverage the £3.8bn 'Sustainability & Transformation Fund' on a non-recurrent basis, to buy-out elements of PFI or LIFT. Secondly, we see opportunities in the better utilisation of the estate that currently exists. As noted in relation to our hospital collaboration plans, we have allocated a one-off capital investment of £3m to this work in order to realise efficiencies of £10m each year going forward. A further £3m annual savings are expected in relation to voids in the primary care estate.

The evidence base for this project includes the Carter Review, Private Finance Unit (PFU) Forum survey and studies and Dudley CCG place-based assessments. We aim to ensure that the estates infrastructure required for service delivery and supporting functions is configured, financed and utilised in the most efficient way, contributing to a 10% reduction in STP estates costs through:

- Survey of current estate – LIFT & PFI – VOIDS
- Health & Local Authority opportunities
- Refinancing opportunities including Local Authority or Independent Trust Financing Facility (ITFF) borrowing
- Unitary payment reduction opportunities (lifecycle, Risk buy back, etc.)
- Elimination of void space
- Challenging planned developments 2017/18 to 2020/21
- Best use of most expensive estate (PFI/LIFT etc.)

Future Commissioning

The future shape of service commissioning within and across the Black Country and West Birmingham needs to be aligned with the evolving nature of service provision. What is set out here reflects initial exploratory work by a number of our commissioning bodies. We will now test and refine our approach with all our commissioning partners.

The Black Country and West Birmingham is currently served by ten commissioning organisations across health and social care. This is likely to lead to:

- Duplication of activity and cost;
- Unnecessary complexity in models of care and in commissioning procedures (including procurement);
- Unwarranted variation in service delivery and outcomes.

Working together within the STP presents us with real opportunities to address these challenges and to look more strategically at the provision of services across the Black Country and West Birmingham, including how they interact with services in neighbouring areas. This work will be led through an STP commissioner group including NHS and Local Authority partners.

New ways of working together as commissioners are required to support the delivery of our local Accountable Care Organisation models, so we aim to simplify and standardise commissioning mechanisms across the Black Country and West Birmingham in order to support Better Health and Better Care, and to remove duplicated costs by:

- Identifying priority areas for streamlining and standardisation – both quick wins and major opportunities; and
- Identifying and evaluating alternative mechanisms through which streamlining and standardisation can best be enabled.

In addition, we aspire to invest an additional £82m annually in developing local healthcare services, subject to achieving an equivalent level of additional savings from our work to reduce demand.

The current NHS planning guidance requires NHS commissioners to agree two-year contracts with providers for 2017/19. This will not only create some medium-term stability for the system but will also afford the opportunity to review our commissioning arrangements in preparation for commissioning services for beyond April 2019.

Our STP sets out two main structures for the delivery of health and social care transformation across the Black Country and West Birmingham:

1. Local Place-based Delivery of Care
   This includes the implementation of the new care models such as the Multispecialty Community Provider (MCP) models in West Birmingham (Modality) and in Dudley Wolverhampton has implemented the Primary Care Home (PCH) model across the majority of practices and has also a Primary and Acute Care System (PACS) type model with the remainder of its practices. As set out above, each of our local areas will have its own locally-appropriate model for delivering place-based care.

2. Extended Provider Collaboration
   This includes the MERIT vanguard and Transforming Care Together Partnership for mental health services, and collaboration on service delivery and support services between the Trusts running our four acute hospitals.

There is, therefore, a clear benefit in organising commissioning arrangements across the Black Country and West Birmingham to enable and enhance the implementation of these two complementary strands. Further consideration also needs to be given to the consequential impact on CCGs once the new models of care have been fully commissioned. The key considerations for each of these issues are set out below, reflecting our core principles of subsidiarity and collective added value.

Local Place-based Commissioning

Each local place-based model shares key characteristics on the need for local public accountability, supporting local community resilience and public health and wellbeing, and the integration of health and social care. Commissioning local place-based care is therefore built on a foundation of partnership working between respective Local Authorities (LAs) and Clinical Commissioning Groups (CCGs). Each local system within the STP will continue to strengthen these partnerships as the basis for commissioning the local placed-based model.

Despite existing contractual arrangements and restrictions leading to services generally being commissioned independently from each other (and often without the right incentives to deliver the agreed model of care), current service delivery is largely being implemented through collaboration between providers and commissioners. To fully support providers in achieving the desired outcomes, however, it will be necessary to change future contracts. This will most likely include moving to Whole Population Based (WPB) arrangements that focus on the achievement of improved outcomes for patients in a local area. This represents a significant change from the current contracts, particularly in health services, that are largely based on activity measures for different items of service.

NHS England has recently issued new frameworks for new models of care, including MCPs and PACS models. These frameworks will subsequently lead to the development of new national contractual frameworks which will enable us to commission local services in a way that supports the preferred model of care. There are some common principles to these new frameworks, regardless of which model is adopted, and these give a clear emphasis on local

population delivery and a priority on achieving improvements in outcomes. It will therefore be desirable to implement these new forms of contracts from April 2019. We are already actively engaged in supporting the development of these new contractual models, providing one of the six national test sites via the Dudley MCP. This creates a further opportunity to use local learning from Dudley to establish a shared understanding and capability across Black Country and West Birmingham CCGs so that, subject to local determination on timing and methodology, we are able to progressively implement these new contractual models in each local system from April 2019.

Black Country and West Birmingham System-wide Commissioning

Earlier sections of our plan set out a clear need for collaboration between our acute service providers. In addition, our Clinical Reference Group (CRG) has reviewed the national Right Care evidence and determined that there are a number of services which would benefit from a strategic clinical review in order to determine the model of service delivery best placed to optimise patient outcomes, the quality of care, and efficiency in service delivery. Those services may include the following (subject to further analysis):

- Cardiovascular Disease (e.g. heart attacks, stroke);
- Endocrine conditions (e.g. Diabetes)
- Genito-urinary conditions (e.g. Chronic Kidney Disease)
- Musculoskeletal conditions (e.g. hip replacement); and
- Cancer.

Our shared objective is to commission acute service delivery so that everyone across the Black Country and West Birmingham can be assured that they will receive the same high quality standard of care regardless of which local hospital they attend. Consequently it will be important for the Black Country and West Birmingham CCGs to collaborate in commissioning these services to the same standards, particularly as our providers are themselves increasingly collaborating on service delivery. This approach will also help to provide a collective commissioning approach to the realisation of efficiencies across our system.

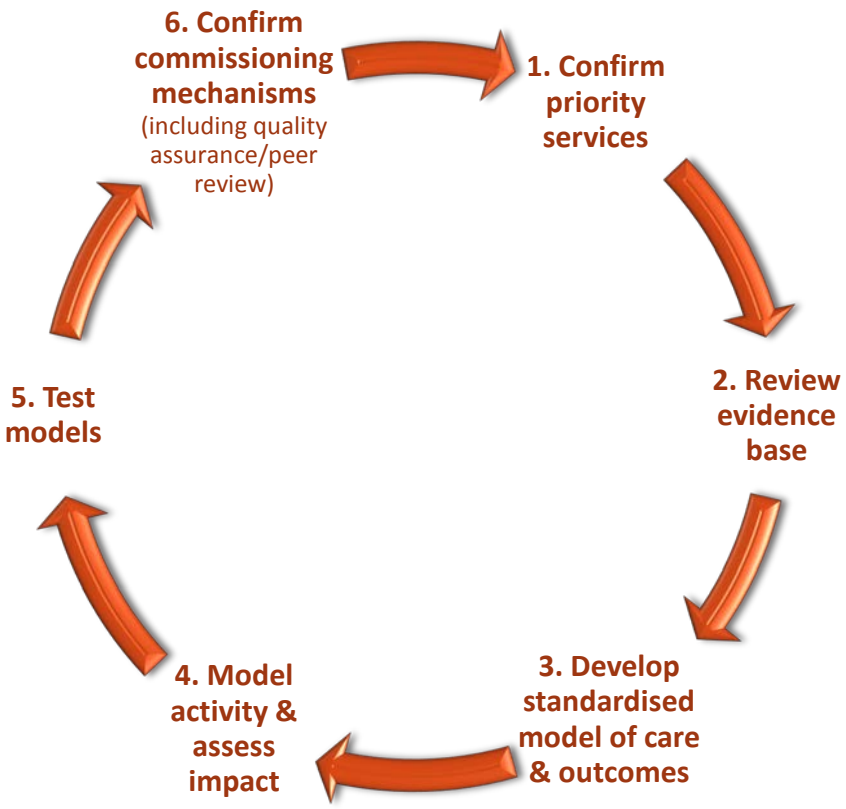
The first stage in this process would be to initiate the proposed clinically-led strategic review. This would be followed by establishing a shared approach to commissioning those services across the four Black Country and West Birmingham CCGs, so that from April 2019 the services can be commissioned through a single shared process across the whole of the Black Country and West Birmingham. The review process is expected to begin in early 2017 and is likely to be an iterative process (see diagram below).

In addition to our local-initiated work, NHSE Midlands and East's Specialised Commissioning Strategic Framework develops a vision to deliver services such as chemotherapy and renal dialysis through networks of provision based around larger specialist providers supporting local services. Specialised Commissioning teams will be working with providers and STPs to

identify opportunities for consolidating services and developing networks. In the Midlands and East region, the larger specialist providers can be categorised into two tiers:

- Tier 1 providers are those that have a large and diverse specialised commissioning portfolio and provide a number of level 1 national services; and
- Tier 2 providers are those which have a large and diverse specialised commissioning portfolio and are a sub-regional specialised centre for a number of services, or a Major Trauma Centre.

OUR CLINICAL REVIEW PROCESS



Although a substantial range of specialist services is provided in Black Country and West Birmingham hospitals, there are no resident Tier 1 providers (patients travel to Birmingham hospitals) and the Royal Wolverhampton NHS Trust is the only Tier 2 provider. This creates the need for a network of acute collaboration across the Black Country and West Birmingham. The framework specifies thirty-six specialised services which could be devolved through the West Midlands Specialised Commissioning Board to a Black Country and West Birmingham commissioning footprint.

Key drivers for commissioning at greater scale include where:

- Outcomes could be improved through service consolidation (e.g. to secure the appropriate clinical competencies)

- Services have interdependencies with other STP footprints (e.g. the configuration of specialist networks including emergency services, trauma care, PPCI)
- Services may not be sustainable as separate local entities (e.g. due to workforce shortage and/or high agency costs)
- Equity of access to high quality care can be improved.

This offers the opportunity to align a Black Country and West Birmingham CCG shared approach to commissioning acute services with the specialised services framework for commissioning through our local Tier 2 provider – to create an integrated Black Country and West Birmingham approach to the commissioning of all major acute services. Our intention would therefore be to work with NHS England to create a joint capacity and capability to commission all of these services from April 2019 on the basis of a single acute network of provision across the Black Country and West Birmingham working to the same standards of care.

This work will also include an independent assessment of the potential impact of the Midland Metropolitan Hospital on services across the Black Country and West Birmingham and, where necessary, the development of plans to address any adverse impact.

Impact of New Care Model Implementation

One aspect of the new care models programme is the opportunity for providers to take on responsibility for providing care to a whole population (e.g. through 'accountable care' type arrangements or Whole Population Budgets). This raises questions about the opportunities for CCGs to contract out some of their functions to providers in a way that has not been not possible before. Whilst the details on what is appropriate will be different for each local system and will be dependent upon the preferred model of care, each CCG Governing Body and its constituent members will need to consider the potential benefits this offers for enhancing the capabilities of local providers and the implementation of the new care models to drive better outcomes and efficiency.

As we move towards outcomes based commissioning and contracting which these new care models afford, the skills and capabilities of commissioners will also need to change. As the component parts of the commissioning system of the STP are addressing these challenges at different paces and with differing timescales, there exists the opportunity for greater collaboration between CCGs to facilitate and accelerate the adoption of new models.

As CCGs evolve to maximise their future effectiveness, it will also be important to consider opportunities for integration of some functions with the regulators, particularly NHS England and the Care Quality Commission, such as service assurance activities. As well as supporting the standardisation of care and the resulting improvement in patient outcomes, this may also enable additional cost savings through a reduction in the tiers of performance management and assurance processes.

A key area in which local commissioners have already been actively collaborating is in relation to urgent and emergency care. This work is summarized below.

Urgent and Emergency Care

The partners in the Black Country STP are committed to ensuring that high quality urgent and emergency care services are provided for patients. We have been working with the organisations that provide urgent and emergency care to make sure that these services are available when they are needed, from facilities as close to home as possible.

The provider organisations have been working together to identify ways to make sure that patients get treated in the right place by the right people. For those people with more serious or life threatening emergency needs we will develop a robust service offer to ensure they are treated 24 hours per day, 7 days per week in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery

This work is going on across the whole of the West Midlands and the Black Country STP is playing a lead role. We have been focusing upon improving access to patient's records so that clinicians can be better informed when making decisions about treatment. In addition we have established NHS111 as a single point of entry into urgent care services and are also developing central points where calls from patients can be taken by doctors and other health professionals including pharmacy, dentist and mental health services. We want to clearly identify which services are available and from where and our work aims to make it as simple as possible for patients to find and get treatment from the service that they need 24 hours per day, 7 days per week.

We are aiming to reduce the need for patients to be transported to hospital by ambulance and we are doing this by making more advice and treatment available at the scene including in patients' homes.

There is developing work involving the providers of mental health services to make sure that patients receive consistent services and that those services are as close to home as possible.

We also want to encourage and support patients to manage their own conditions and to give them more information to help them understand what they can do to avoid the need to see a doctor or go to hospital.

Significant work has also been done to ensure that patients can get urgent treatment from their GP, dentist or pharmacist.

Patients and their carers have been heavily involved in the development of our work on urgent and emergency care from the beginning including co-design events, participation in the Urgent and Emergency Care Network and involvement in procurement processes.

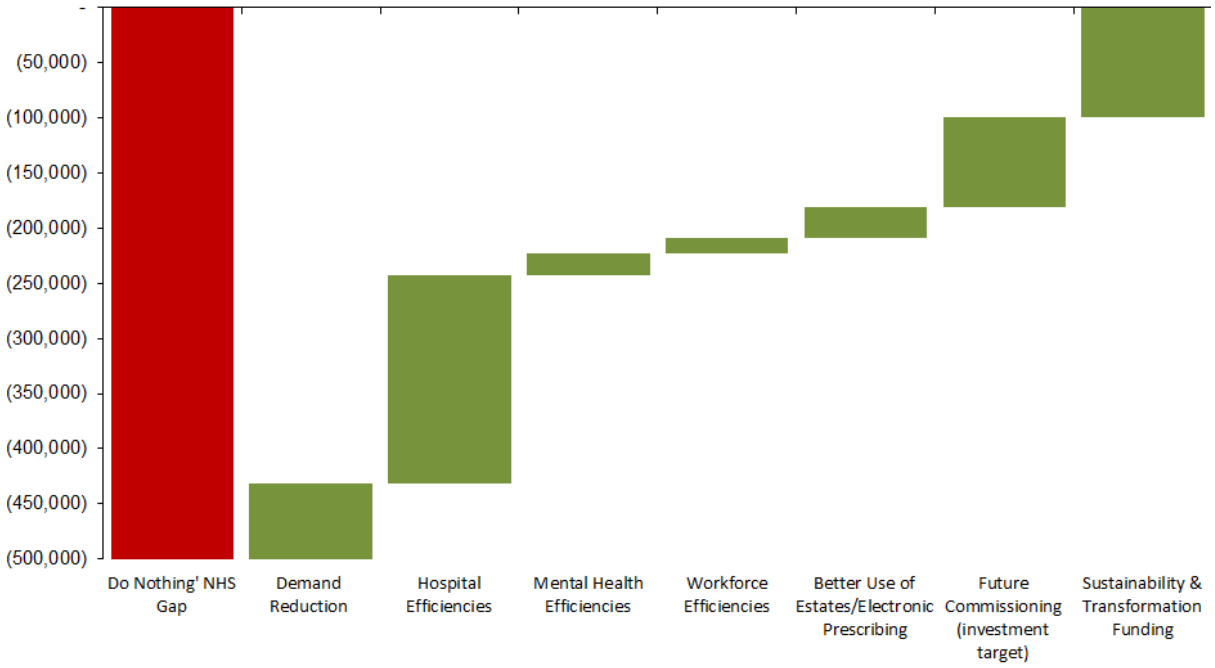
Financial Sustainability and Investment in Transformation

To achieve sustainability in local health services, the Black Country STP needs to take significant action to reduce both the projected growth in demand and the costs of the services provided. The challenge equates to avoiding spending of £512m by 2020/21. With an indicative national Sustainability and Transformation Fund allocation of £99m in 2020/21 that leaves a local challenge of £413m. The table below summarises how our transformation plans will contribute to building a financially sustainable healthcare system for the Black Country and West Birmingham. To be updated

The Gap		The Solutions
£700m 2020/21 STP 'Do Nothing' Gap	£512m Health £413m savings + £99m STF	£81m Demand Reduction through Local Place-based Models of Care
		£189m Efficiency at Scale through Extended Hospital Collaboration
		£20m Improving Mental Health and Learning Disabilities Services
		Getting the Best Start - Improving Maternal & Infant Health
		£14m Workforce Enabler
		£27m Infrastructure Enabler (estates and technology)
		£82m Future Commissioning
		Addressing the Wider Determinants of Health
	£188m Social Care	Local Authority Investment & Savings Plans

Individual organisations retain responsibility for delivering annual savings and efficiency targets, albeit with the increased mutual support available through STP structures and processes. There is currently a requirement for providers to deliver a 2% CIP and for CCGs to keep demand 1% under the average annual growth of 2.3%. Achieving against these challenges will deliver £235m out of the local £413m challenge. This makes it clear that we need the added value of increased collaboration through the STP to avoid future costs of a further £178m.

The diagram below sets out how sustainability will be achieved for Black Country and West Birmingham health services by 2020/21.



In order to achieve this, we will need to make some targeted capital investments. Our plan proposes the following allocations beyond what features in the separate investment plans of each of our organisations:

- £34m for primary care premises
- £16m for premises changes to support other closer to home services
- £35m to support networks of acute care excellence
- £10m for estates changes required to deliver Mental Health and Learning Disability services transformation
- £3m to enable the release of £10m annual efficiencies relating to estates
- £5m to enable the release of £24m annual efficiencies relating to prescribing.

Transformative Impact through Rapid Cycle Learning

We wish to become one of the most innovation-aware and adoption-ready health and care economies in the country. Our existing innovations (such as our Vanguard models of care) and the developments set out in this plan would give us the ability to systematically study and compare different approaches, to harvest and codify good practice and to actively support its adoption.

> **The single most important change in the NHS…. would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.**
>
> *Berwick Report, 2013*

We intend to demonstrate the power of this approach to the wider NHS and to make practical learning central to what we do.

Maximising the value of knowledge exchange relies upon defining the right focus and questions. For example:

- Dudley is developing an MCP under the New Care Models programme (other areas have plans for them) and Wolverhampton is adopting PCH and PACS models. Marrying international and national evidence with local experience, we will be able to examine the arguments for the adoption of each model, the component parts of them, the practicalities of implementing them and the effects that result. In effect, we would treat the Black Country and West Birmingham as a microcosm of the New Care Models programme, with a rapid route to adoption;

- Whilst on one level there is a choice between types of new care models, it is likely that their component parts will be similar. Each typically includes some form of enhanced / scaled up primary care; each features community based teams over populations of thirty to fifty thousand; each makes use of more intensive multi-disciplinary teams focused on higher risk patients. This provides opportunities for cross-model learning. We will be able to select a common component and focus knowledge exchange on its design and operation. For example, how do we provide community based teams with the information they need to effectively manage 'their' populations?

- We, like most areas of the country, need rapidly to learn how best to take advantage of the unrealised opportunities for efficiency at scale and how best to deliver increasingly specialized services across a population of 1-2 million people. Should a service area focus be taken – urology has been identified as an example – this would allow knowledge exchange activity to use clinical peer review as a mechanism. Again,

involvement of clinicians would provide for rapid adoption of identified improvements;

- We have already identified the need to make rapid improvement in relation to MHLD and maternity services. In addition to learning about how services are best configured and operated, we also need to understand the potential impact of wider system drivers such as public health measures and the role of voluntary organisations, employers and the public. Such a breadth of approach is necessary given the wider determinants of problems as complex as infant mortality and mental health. Our approach here is likely to be more place-based, asking (for example) what each local area does on public mental health, what seems to work well and where improvements are needed.

Exploring questions such as these is no abstract exercise without urgency. In order to build a transformed and sustainable health and care system that makes an increased contribution to local wellbeing and prosperity, we need to learn rapidly from what we do. Every year, the NHS is the Black Country and West Birmingham has some nine million patient contacts undertaken by over 30,000 healthcare staff. This provides us with a vast live evidence base and a huge team of learners. With the right mechanisms in place we believe we can make the Black Country and West Birmingham a health and care system that quickly and continually adapts itself as a result of what it learns day by day.

The mechanisms we will be exploring include:

- Structured peer review cycle across the STP (e.g. between integrated community teams or acute specialty teams);
- 'Living Review' function (building on the current provision for the Dudley MCP Vanguard) to help our workforce learn from research and practice in a timely way. It would keep staff up to date with new evidence as it emerges, distilling key messages and translating them into a local context;
- How to use technology to enable the rapid spread of learning across both front line teams and the system as a whole. For example, it is feasible to envisage integrated community team members equipped with portable devices that:
    - Provide access to a shared care record;
    - Enable activity recording; and
    - Facilitate social media type comments about how services are working for patients and staff (new ideas, positive or negative feedback on developments, identification of system blockages).

  Potential benefits might include near real-time peer-to-peer learning for operational staff, ability for strategic evaluation through in-depth analysis of qualitative feedback,

cross-referenced to any changes in activity patterns and feedback from evaluation both to front-line staff and to other STPs/regulators for wider learning.

- Targeted local analytical reports designed to respond to identified team priorities with built in loops to measure improvement.

Communications and Engagement

Our Strategy outlines our plans on engaging and communicating effectively with our patients, public, partners, staff and stakeholders across the Black Country on how we will work with them to improve the health and care of people of the Black Country and west of Birmingham.

We recognise what people and communities want from their local health and care services and could do for themselves and by reorienting and reshaping health and other services to support them. This shift from a clinically and managerially led process to a coproduced approach to health and care is at the heart of our plans around communication and engagement.

Communication and engagement need to be at the heart of how we move forward if we are to transform local services in order to make them sustainable for the future and more responsive to the needs of the people we serve. In other words, the voice of the patient needs to be central to everything we do.

The way that health and care is provided has dramatically improved over the past fifteen years – thanks to the commitment of NHS staff and protected funding in recent years. However, some challenges remain. The quality of care that people receive can be variable; preventable illness is common; and growing demands on the NHS means that local health and care organisations face financial pressure.

The needs and expectations of the public are also changing. Fortunately we are living longer, but we often require different, more complex care as a result. New treatments options are emerging, and we rightly expect better care closer to home.

There is broad agreement that, in order to create a better future for the NHS, we have to adapt the way we do things. This doesn't mean doing less for patients or reducing the quality of care. It means more preventative care; finding new ways to meet people's needs; and identifying ways to do things more efficiently.

Two levels of activity are planned:

- STP programme level – high-level communications activity in support of the Programme, and the management of communication and engagement interfaces with contiguous strategic work programmes (including the Health Care Review; NHSI Financial Improvement Programme.)

- STP work stream level – supporting specific STP work streams to develop and implement a detailed, operationalised communications and engagement plan (or plans) to support their specific work programmes.

STP partners have committed to ensure all of our communications support local people to understand all of the issues which the programme seeks to balance. There will be many

different interests and only by working together, to discuss and debate the relative needs of local people, as well as the safety and quality of services proposed, can we fully ensure all interests are properly represented.

We will ensure we promote ways of working together which are in the interests of local people, who will remain at the heart of the development of this programme.

We will commit to communicate in a way that is:

- Open and transparent – our communication will be as open as we can be, ensuring that when the information cannot be given or is unavailable, the reasons are explained
- Consistent – There are no contradictions in the messages given to different stakeholder groups or individuals. The priority to those messages and the degree of detail may differ, but they should never conflict
- Two-way – There are opportunities for open and honest feedback and people have the chance to contribute their ideas and opinions about issues and decisions
- Clear – Communication should be jargon free, to the point, easy to understand and not open to interpretation
- Planned – Communications are planned and timely rather than ad-hoc and are regularly reviewed to ensure effectiveness
- Accessible – Our communications are available in a range of formats to meet the needs of the target audience
- High quality – Our communications are high quality in relation to structure, content and presentation at all times.

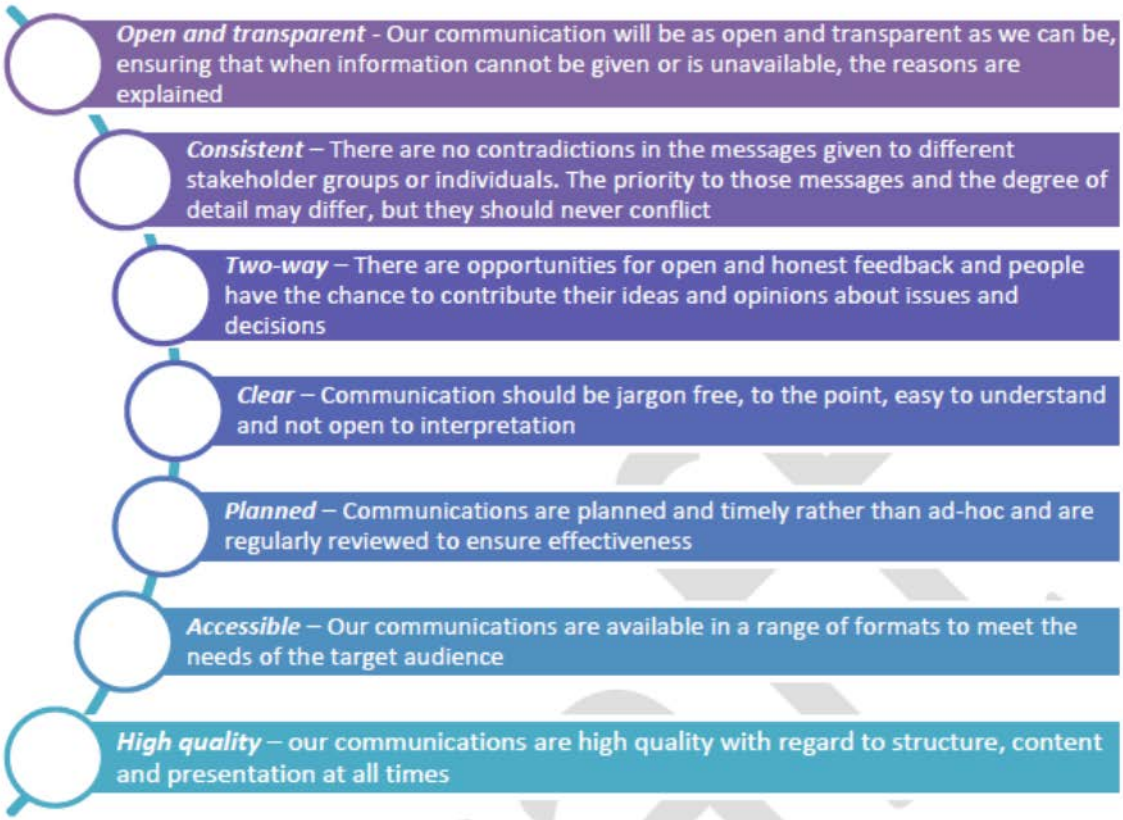
We will actively provide the following channels for communication, sharing, learning and strategic advice:

- Communications Concordat
- Local communications and engagement networks
- Communication and Engagement leads on each transformation work-stream
- Communications and Engagement lead to attend/report into the Operational Group
- Communications and Engagement lead to attend/advise Sponsoring Group

This concordat makes a commitment to publish a quarterly statement of programme progress as a minimum.

The five community empowerment dimensions above are helpful in thinking about how we work with people. Empowerment is not just about the people and communities, it is also about organisational structures and processes being empowering. When developing new ways of working we will take an empowering approach to engagement.

- By 'confident', we mean, working in a way which increases peoples skills, knowledge and confidence – and instills a belief that they can make a difference.
- By 'inclusive', we mean working in a way which recognises that discrimination exists, promotes equality of opportunity and good relations between groups and challenges inequality and exclusion.
- By 'organised', we mean working in a way which brings people together around common issues and concerns in organisations and groups that are open, democratic and accountable.
- By 'cooperative', we mean working a way which builds positive relationships across groups, identifies common messages, develops and maintains links to national bodies and promotes partnership working.
- By 'influential', we mean working in a way which encourages and equips communities to take part and influence decisions, services and activities.



Over the summer we have been working with partner organisations to refine our plans. During this time we have continued with a programme of communication and engagement events involving staff and other key stakeholders, to build understanding and support for our rationale and approach to change. Key aspects of our plans had themselves been subject to previous public engagement and, in some case, formal public consultation.

This engagement will continue and intensify following the publication of this plan, in a format that is accessible to our patients, public staff and wider stakeholders. We will be in a position to articulate the benefits for our patients in a way that they can understand and relate to through the publication of a document that gives the public a good understanding of the need to change. Throughout the Autumn we will be taking our plan through our partner organisations' governance processes. We will be presenting our plans to a wide range of key stakeholders, including:

- Health and Well-being Boards
- Overview and Scrutiny Committees
- Local Professional Committees, for example LMCs
- Healthwatch
- Patients and their carers through existing mechanism such as PPGs, FT Governors, Patient Advisory Groups etc.
- The public - through in-reach into Libraries, local housing forums, Citizen Forums etc.
- Reaching out through the local voluntary and community sector infrastructure organization to local community based organisations
- Utilising existing channels to communicate and engage staff and clinicians

We will take advantage of existing systems to capture patient and public insight, experience data in order to fully understand and inform the specific plans for change arising out of the workstreams. We will adopt a co-design and co-production approach to ensure that our plans for transforming the health and care of people across the Black Country and West Birmingham are sustainable and achieve real change.

It is important that we make best use of existing communication channels and build on place based relationships. We have undertaken a stakeholder analysis to understand who our stakeholders are and how we best communicate with them. For example we will continue to communicate with our patients, people who use our services, their carers and their communities by using existing forums, such as citizen panels, patient networks, patient participation groups, community events. Social media will also continue to feature in respect of how we get our messages out.

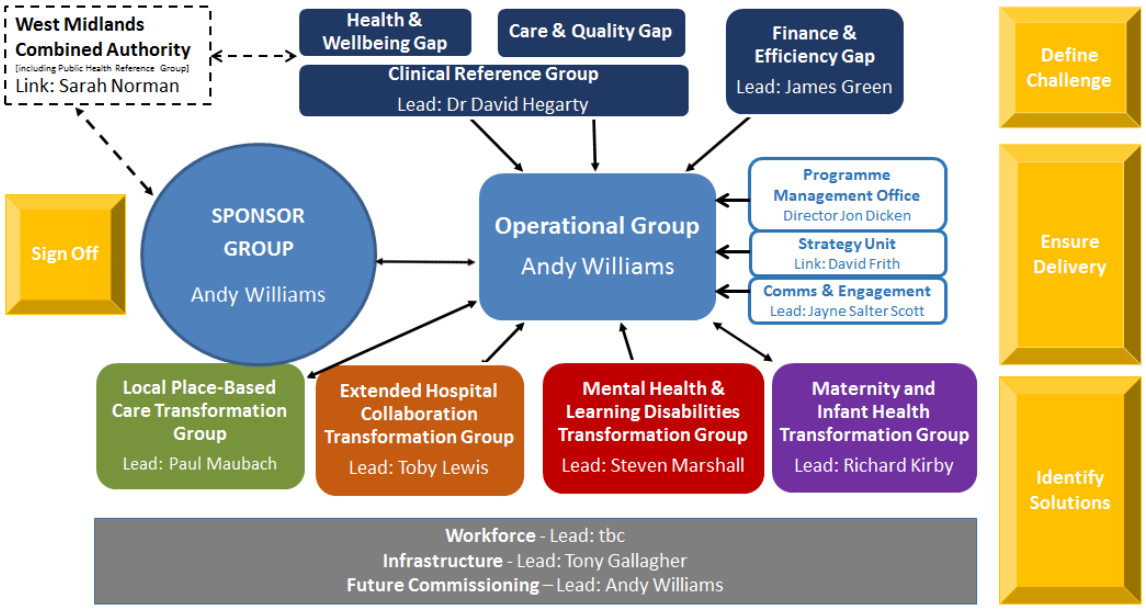
The success of our STP also relies on our relationship with our patients, people who use our services, our staff and clinicians. We will take an engaging and co-production approach to our STP by getting patients, people who use our services, our staff and clinicians to lead change. Taking decisions together, we will ensure that collective action can make a positive difference to the health and care of people across the Black Country and West Birmingham.

Ten Priority Questions

1	**How are you going to prevent ill health and moderate demand for healthcare?**	Our plans for local place-based models of care address the need for better health and will also serve to moderate demand.
2	**How are you engaging patients, communities and NHS staff?**	The communications concordat makes a commitment to publish a quarterly statement of programme progress as a minimum. Engagement with patients, communities and NHS staff will continue to be led by partner organisations in ways appropriate to local circumstances.
3	**How will you support, invest in and improve general practice?**	The development of place-based models of care, building on local Vanguards, will strengthen the resilience of primary care services and enable re-design appropriate to each locality.
4	**How will you implement new care models that address local challenges?**	New models of care are already active within and across the four Black Country and West Birmingham boroughs, and each area will implement a model which addresses access, continuity and coordination challenges. Our local evaluation methodology will enable rapid learning across all areas.
5	**How will you achieve and maintain performance against core standards?**	Our plans for standardised best practice in place-based models of care will reduce the pressure on the urgent and emergency care system; and our analysis shows significant potential to reduce first: follow-up ratios, improving RTT.
6	**How will you achieve our 2020 ambitions on key clinical priorities?**	Standardisation of acute pathways will improve cancer survival; prioritisation of Mental Health transformation will improve access & outcomes; standardisation of maternity pathways will improve experience and outcomes; and Strategy Unit analysis will inform improved intervention along the Dementia pathway.
7	**How will you improve quality and safety?**	Improvements will be achieved through standardisation of place-based care models and of priority acute pathways. A system-wide ePrescribing system will support antimicrobial resistance through reducing inappropriate prescribing.
8	**How will you deploy technology to accelerate change?**	Our digital strategy will enable benefits in vertical and horizontal integration initiatives. These will both drive digital requirements and be partially shaped by digital potential (e.g. collaboration, analytics, big data, infrastructure).
9	**How will you develop the workforce you need to deliver?**	Our horizontal integration work will drive a new scale of workforce efficiency (including around agency spend). We are also initiating a discrete project to develop new roles (e.g. physicians associates, nursing associates, assistant practitioners, integrated health and social care apprentices) to underpin new models of care.
10	**How will you achieve and maintain financial balance?**	Balance will be achieved by 2020/21 through partner organisations delivering against their regulatory or statutory duties with an additional scale of savings delivered through collective opportunities at STP level.

Programme Governance

The sponsor organisations of the STP have agreed the following governance structure:



Oversight of the plan's development and implementation lies with the Sponsoring group which is constituted as follows:

Chair/Lead: Andy Williams

Organisation	Named Lead	Named Deputy
Black Country Partnership NHS Foundation Trust	Tracy Taylor	Tracey Cotterill
Dudley MBC	Sarah Norman	Matt Bowsher
Dudley Group NHS Foundation Trust	Paul Harrison	Anne Baines
Dudley and Walsall Mental Health Partnership NHS Trust	Mark Axcell	Mary Bytheway
Dudley CCG	Paul Maubach	Matt Hartland
Sandwell MBC	Jan Britton	David Stevens
Sandwell & West Birmingham Hospitals NHS Trust	Toby Lewis	
Sandwell & West Birmingham CCG	Andy Williams	
Walsall MBC	Paul Sheehan	
Walsall Healthcare NHS Trust	Richard Kirby	Daren Fradgley
Walsall CCG	Paul Maubach	Tony Gallagher
Wolverhampton City Council	Keith Ireland	Linda Sanders
Royal Wolverhampton NHS Trust	David Loughton	Mike Sharon

Organisation	Named Lead	Named Deputy
Wolverhampton CCG	Trisha Curran	Steven Marshall
Birmingham City Council	Alan Lotinga	
Birmingham Community Healthcare NHS Foundation Trust	Tracy Taylor	Lorraine Thomas
NHS England	Alison Tonge	Alastair McIntyre
West Midlands Ambulance Service	Anthony Marsh	Mark Docherty
Local Government Association	Joe Simpson	
Healthwatch	Jayne Emery	
Health Education England	Della Burgess	

Workstream and Transformation Group leads together form the Operational Group:

Transformation Group/Workstream	Named Lead	Named Deputy
Sponsoring Group	Andy Williams	
Local Place-based Care	Paul Maubach	Jo Taylor
Extended Hospital Collaboration	Toby Lewis	
Mental Health & Learning Disabilities	Steven Marshall	Mary Bytheway Sarah Fellows
Maternity & Infant Health	Richard Kirby	Sally Roberts
Workforce	tbc	Della Burgess
Infrastructure	Tony Gallagher	
Future Commissioning	Andy Williams	
Link to WMCA on Wider Determinants	Sarah Norman	Karen Jackson
Health & Well Being	David Hegarty	Jim Young
Care & Quality		
Finance & Efficiency	James Green	
Communications & Engagement	Jayne Salter Scott	
Programme Management	Jon Dicken	

A quality assurance function (QA) will be exercised by our CRG that will:

- Provide robust clinical assurance to each transformation group and workstream, supported by patient engagement;
- Be based on an evidence-based methodology developed in the Black Country and West Birmingham for the West Midlands Clinical Senate (and now endorsed by National Senate Chairs);

- Complement and provide evidence for any external assurance processes that may be required for aspects of our plan from time to time.

The partners to the STP have all worked collaboratively over recent months and have contributed to the development of the content of the plan for the Black Country and West Birmingham setting out aspirations for transformative and sustainable developments. The next stage will be to formally engage and consult with stakeholders on the plan. This will then facilitate formal sign off of the plan over the coming months.

Programme Plan

The STP has established a dedicated Programme Management Office which has developed a detailed programme plan and is monitoring workstream activity against this. The following table summarises key milestones for the STP during 2016. Summary plan templates for each main area of activity can be found in the appendix.

Subject to sign off and approval of the plan by the national sponsoring bodies we will move to implementation, this will see a review of our governance and leadership of the STP. Our intention is to place clinicians at the head of our governance so that the STP is a clinically led managerially supported process. It is essential that we build upon the advice and guidance provided through our Clinical Reference Group and effectively engage the clinical (and non-clinical) workforce.

Our clinical leaders will enhance the credibility of our plans when we consult and engage with patients and wider stakeholders as our plans mature and the implementation gathers momentum during the coming weeks, months and years.

The implementation of the STP rests firmly upon each of the localities and the constituent partners including patients, providers and commissioners. This approach recognises the principal of subsidiarity which has been central to the STP since its inception, it also recognises the wealth of existing work taking place across the Black Country and West Birmingham and ensures continuity whilst recognising the opportunities for further and wider collaboration and integration through the STP.

The Black Country Sustainability and Transformation Plan – Key Milestones

Year	2016/17				2017/18				2018/19				2019/20				2020/21			
Activity	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Local Place Based Models of Care																				
Mapping current intentions and models in each borough																				
Adoption of a developmental evaluation framework																				
Standardised access to services through the new integrated urgent care service																				
Improving long-term conditions and care pathways supported by Integrated Care Teams																				
Better coordination of care for frail elderly and those with complex needs																				
Learning from our vanguard sites to implement new incentive and risk management models																				
Extended Hospital Collaboration																				
Develop shared/single service plans for acute specialities with particular opportunities/challenges																				
Develop new models of care to support specialised services including cancer/vascular																				
Develop options for delivering efficiency in pathology services																				
Extending collaboration in back office services																				
Complete MMH development																				
Commission for Quality in Care Homes																				
Delivery individual CIPs	ANNUAL																			
Improving Mental Health & Learning Disabilities Services																				
One Commissioner																				
Build the Right Support for LD																				
Improve bed utilisation and stop OATs																				
Delivering the CA MH challenges																				
Deliver extended efficiencies through TCT partnership																				
Improving Maternal & Infant Health																				
Implement the recommendations of the Cumberledge																				

The Black Country Sustainability and Transformation Plan – Key Milestones

Year	2016/17				2017/18				2018/19				2019/20				2020/21			
Activity	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
report																				
STP-wide network for sharing intelligence and best practice on maternal, neonatal and infant health																				
Black Country Healthy Preconception and Pregnancy pathway																				
Identify opportunities for system wide action on the wider determinants of health																				
Model maternity capacity projections across the Black Country and develop options for delivery																				
Ensure best practice arrangements for birth agenda, improving maternity safety outcomes across the Black Country																				
Workforce																				
Clarify STP workforce implications to deliver transformation	ONGOING																			
Scoping of new and existing workforce hotspot areas																				
Robust methodology for workforce planning across the system																				
Work plan on the priorities identified by the LWAB from the STP and Human Resources perspective.																				
Understand the Carer and Volunteers workforce to identify good practice and make recommendations on areas for development																				
Infrastructure																				
Explore potential to buy-out elements of PFI or Lift																				
Review utilisation of current public estate and develop options for more efficient usage																				
Form Black Country Digital Transformation Board																				
Develop Digital Delivery Plans to take us from current state (16/17) to digitally enabled state (17/18) to connected state (18/19) to integrated state (19/20)																				
Accelerate & support extant plans within organisation & LDR footprints																				

The Black Country Sustainability and Transformation Plan – Key Milestones

Year	2016/17				2017/18				2018/19				2019/20				2020/21			
Activity	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Identify & deliver 'quick wins'																				
Future Commissioning																				
Identify priority areas for streamlining and standardisation																				
Strengthen collaborative commissioning between CCGs and Local Authorities on a place-based basis	ONGOING																			
Undertake clinically led service reviews (informed by Clinical Senate Assurance framework)																				
Identify and evaluate new contracts types and organisational forms																				
New commissioning arrangements implemented and relationship with regulators confirmed																				
Assess system-wide impact of MMH and develop plans in response (as required)																				
Addressing the Wider Determinants of Health																				
Develop and implement a range of evidence-based recommendations that support the whole prevention agenda																				
Implement the recommendations of the Mental Health Commission once published.																				
Deliver programmes across the Black Country to address key lifestyle risk factors, mobilising health and social care systems to deliver Making Every Contact Count and mental health literacy.																				
Develop STP-wide network of best practice.																				
Work across health and social care system including the WMCA																				

THE BLACK COUNTRY

Sustainability and Transformation Plan Summary

October 2016

SUMMARY

The local NHS wants to make some common sense changes so people in the Black Country and West Birmingham get the treatment they need as quickly as possible. This will mean more money going into GP services – creating more appointments, giving doctors and nurses more to time to go and visit patients at home, and linking up GPs with hospital specialists. Patients can expect to see a number of changes happening in their area.

- With an extra £25m invested in GP services by 2021, an extra 25,000 primary care appointments a year will be made available. All children under 5 and adults over 75 will be guaranteed same day access to GP appointments, meaning 200,000 people will be able to see a family doctor when they need to.
- Over 1,000 people a month who turn up at A&E will be able to have their problem assessed and treated by a GP, reducing waits and improving care.
- Across the Black Country and West Birmingham, there will be at least 40,000 additional home visits, clinics and appointments offered in local surgeries and health centres, as close to home as possible.
- From November 2016, by ringing one telephone number the 1.4m people who live in the Black Country will be able to book a doctor's appointment, in the evening and at the weekend, get dental advice, order a repeat prescription, or get urgent advice.
- By 2021, over 100,000 people will be saved a trip to hospital for their outpatient care, with more treatment offered in local GP surgeries and health centres.
- By bringing all cancer services up to the standard of the best, cancer one year survival rates will reach over 70 per cent in the Black Country and West Birmingham.
- Common sense changes to the way our family doctors, hospitals and care services work together will reduce the number of people visiting A&E by 3,000 a week by 2021, meaning faster treatment and care for the most seriously ill.
- By 2021, instead of having to be admitted as an emergency to hospital, an extra 1,000 people each week will be cared for in their own home or local community by doctors, nurses and paramedics.
- Around 34,500 patients with long term conditions, such as diabetes or heart problems, will be given technology to monitor their heart rate and bloody pressure remotely, alerting the doctor if there are any signs of deterioration so problems can be nipped in the bud early.
- Local clinical teams involving GPs, community nurses, mental health services and social care will provide better coordinated care for our most vulnerable patients with very complex needs.
- The new Midland Metropolitan Hospital will bring hospital services in Sandwell and West Birmingham together in one place to treat over 570,000 people in a state of the art building.
- By using our specialist NHS staff in a different way, patients who suffer major trauma, stroke, heart attack, or those who have cancer, kidney failure or breathing problems will receive the best treatment and care.
- Changes to how health and care services work together will mean those suffering early psychosis will get access to therapy within two weeks.
- The NHS in the Black Country and West Birmingham will reduce current high levels of infant mortality to bring it in line with the national average, avoiding the death of 34 babies a year - the equivalent of one child every eleven days.
- By tackling waste, improving standards and working together, we can avoid a potential increase in health costs of over £413million per year by 2021. This will give better value to the taxpayer, equivalent to £680 a year for every household in the Black Country and West Birmingham.

SUMMARY

Partnership Working

This plan is a 'work in progress' on which partners to the STP have all worked collaboratively over recent months. It sets out aspirations for transformative and sustainable developments. The next stage will be to formally engage and consult with stakeholders on the plan so that it can be further developed before formal approvals are considered.

Progress to Date

We drafted an initial outline plan in June. Since that time we have taken substantive steps forward (see over for detail) so that our plans now set out:

- ✓ Further detailed analysis that has been undertaken to understand the challenges we face in health, care and resourcing, supported by a review of priorities by our own newly established Clinical Reference Group;
- ✓ A year by year (and organisation by organisation) breakdown of how we will deliverable a sustainable local health economy;
- ✓ More granular project plans for the actions we will take going forward to address those challenges;
- ✓ The specific benefits that we expect our plans to deliver, not least in terms of patient outcomes; and
- ✓ A clear sense of what we can achieve together at pace and scale (an additional c.£90m avoided cost) beyond what could be delivered through business as usual.

Stakeholder Engagement

Over the summer we have been working with partner organisations to refine our plans. During this time we have continued with a programme of communication and engagement events involving staff and other key stakeholders, to build understanding and support for our rationale and approach to change. Key aspects of our plans had themselves been subject to previous public engagement and, in some case, formal public consultation. This engagement will continue and intensify post submission with the publication of our full plan in a format that is accessible to our patients, public, staff and wider stakeholders. We will be in a position to articulate the benefits for our patients in a way that they can understand and relate to through the publication of a document that gives the public a good understanding of the need to change. Throughout the Autumn we will be taking our plan through our partner organisations' governance processes, and we will be presenting our plans to a wide range of key stakeholders.

Next Steps

Subject to sign off and approval of the plan by the national sponsoring bodies we will move to implementation, this will see a review of our governance and leadership of the STP. Our intention is to place clinicians at the head of our governance so that the STP is a clinically led managerially supported process. It is essential that we build upon the advice and guidance provided through our Clinical Reference Group and effectively engage the clinical (and non-clinical) workforce. Our clinical leaders will enhance the credibility of our plans when we consult and engage with patients and wider stakeholders as our plans mature and the implementation gathers momentum during the coming weeks, months and years. The implementation of the STP rests firmly upon each of the localities and the constituent partners including patients, providers and commissioners. This approach recognises the principal of subsidiarity which has been central to the STP since its inception, it also recognises the wealth of existing work taking place across the Black Country and ensures continuity whilst recognising the opportunities for further and wider collaboration and integration through the STP.

Priority Area	Progress since June	Key Benefits Expected

Local Place-based Care	An overarching framework has been defined for our local model of care to deliver improvements in access, continuity and coordination of care. Each of our areas has set out a locally-appropriate implementation model for improving care and reducing demand, including the outcomes to be achieved.	• **Urgent Care.** From November 2016 Black Country patients will have easier access to urgent advice and treatment 24/7 from a range of clinicians via a single phone number.
		• **New Models of Care.** Benefits in our localities will include:
		  • Same day GP access for under 5s and over 75s
		  • Telehealth pilots for 34,500 patients in Dudley
		  • Increasing community contacts by approx. 25,000
		  • Create new integrated Health and Care Teams covering 30k-50k populations
		  • Access to a full range of standard primary medical services during core hours and essential services 24/7.

Extended Hospital Collaboration	Plans to deliver efficiencies in support services and to make high-locum specialties more sustainable are now set out. Detailed analysis has been undertaken to map the activity, cost and performance of a range of specialties that may most benefit from collaboration; to identify opportunities for reducing admissions from (and delayed transfers to) care homes; to verify that CIPs are addressing BCBV opportunities; and to clarify the system impact of the MMH development.	• Patients getting the very best care through a shared network of expertise • Improve patient outcomes through standardising how hospitals provide care – for example, heart attack, stroke, diabetes, kidney disease • Complete development of a new acute hospital serving 570,000 patients
Mental Health & Learning Disability Services	A route map and delivery timeline have been developed, supported by an extended governance structure and detailed plans for sub-projects. We have also developed a deeper understanding of the physical health needs of mental health service users and how we can better address them.	• Reduce the number of patients who have to travel out of area to receive their care – for example, specialist children's services • Simplify access to services improving health and wellbeing for users, families, staff and communities • Improve all age Early Intervention services; • Reduce variation in care and service delivery across the Black Country
Maternal & Infant Health	A plan of action has now been defined to reduce infant mortality, agree a sustainable model for maternity and neonatal services and to address the Better Birth agenda. A capacity review has been initiated. We now also have a detailed understanding of the human and economic impact of poor maternal health and poor infant outcomes.	• Avoiding the unnecessary death of an infant every 11 days through reducing Black Country infant mortality rates to the England average • Options for how to access maternity services and where to birth your baby, developed with local mums • A range of health and care support tailored to mothers and families needs during pregnancy
Future Commissioning	We have now set out an approach for streamlining and standardising the commissioning of services to improve quality of care, patient outcomes and system efficiency.	• Commissioners will ensure that patients get the best care wherever they receive it in the Black Country • We will maximise our spending on services by removing unnecessary administrative costs
A Learning System	We are determined to use real-time learning from our range of local innovations to drive change, not just to implement new models and trust they will deliver. We have set out a range of approaches that we will consider, and identified some of the questions we will want to explore to maximise learning from our initiatives.	

Our Transformation Logic Model

Rationale for our STP

The Black Country and West Birmingham health and care system faces significant challenges. Some of these challenges are a function of changes in population need; others are a function of the way we organise and provide services; others grow from the way we engage with patients and the public. We face resulting gaps in care quality, health outcomes and financial sustainability. We must therefore act on multiple fronts. The STP provides us with a framework for doing this. It is an opportunity to act systematically and in concert - to agree upon and address common challenges in a way that we could not as individual constituent parts.

Inputs

In-kind contributions of all BC partners: clinical and managerial resources

Analytical inputs

Programme infrastructure

Additional funding allocations (including £99m Sustainability and Transform-ation Funding)

Activities

1: 'LOCAL PLACE-BASED MODELS OF CARE ': Develop standardised place-based Integrated Care Models commissioned on basis of outcomes; Promote prevention agenda & build resilient communities;

2: 'EXTENDED COLLABORATION BETWEEN SERVICE PROVIDERS': Build network of secondary care excellence; Deliver efficiencies in support services; Complete acute reconfiguration through Midland Metropolitan Hospital; Commission for quality in care homes; Deliver Cost Improvement Programmes;

3: 'MENTAL HEALTH & LEARNING DISABILITIES': Become one commissioner for NHS services, Build the right support for Learning Disabilities in association with Council commissioning functions, Improve bed utilisation and stop out of area treatments, Deliver the WM Combined Authority Mental Health challenges, Deliver extended efficiencies through TCT partnership;

4: 'MATERNITY & INFANT HEALTH': Develop standardised pathways of care for maternal/child health; Review maternity capacity

5: 'ENABLERS': Systematically evaluate and learn from process of implementation and evidence based practice; Undertake workforce transformation and reduce agency use; Implement BC Digital Strategy; Rationalise public sector estate; Consolidate back office functions; Develop future commissioning functions

6: 'WIDER DETERMINANTS': Link to West Midlands Combined Authority to address wider determinants and maximise health contribution to economic impact

Outputs

Proactive and efficient model of place-based care codified and commissioned

Pathways codified and streamlined / standardised

Back office / estates / supporting functions consolidated

Digital Strategy implemented

New workforce roles developed

Lessons from implementation & from the evidence

Outcomes

Reduced unwarranted variation in care quality and outcomes

Improved patient experience (and reduced variation in)

Increased proportion of care provided in out of hospital settings

Integrated service delivery

Reduced per capita expenditure

More proactive and risk stratified care; reduced unplanned care

More engaged and productive workforce

Better use of available public sector infrastructure

Increased use of intelligence and insight

Impacts

A more sustainable local health and care economy

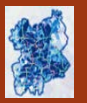
Improved quality & experience of care for the population of the Black Country

Improved population health: greater quality and quantity of life

A more capable local economy, equipped for self-improvement

A happier, more sustainable workforce

Sustainability Solutions



£700m 2020/21 STP 'Do Nothing' Gap	£512m Health (£413m savings + £99m STF)	**Demand Reduction through Local Place-based Models of Care £81m**	• Eliminating unwarranted variation and improving access to primary care through standardised outcomes and model of delivery. • Achieving integrated continuity of care for the 1/3 of the population with Long Term Conditions – improving management and reducing admissions for chronic conditions. • Delivering better coordination of care to reduce unscheduled admissions.
		Efficiency at Scale through Extended Hospital Collaboration £189m	• Creating Networks of Secondary Care Excellence • Efficiency in Clinical and Non-Clinical Support Services • Midland Metropolitan Hospital Development • Commissioning for Quality in Care Homes • Effective Delivery of Cost Improvement Programmes
		Improving Mental Health and Learning Disabilities Services £20m	• Become one commissioner for NHS services • Build the right support for Learning Disabilities with Council commissioning functions • Improve bed utilisation and stop out of area treatments • Deliver the WM Combined Authority Mental Health challenges • Deliver extended efficiencies through TCT partnership
		Improving Maternal and Infant Health	• Closing the Infant mortality gap • Developing a sustainable model for maternity and neonatal services • Delivering National Better Birth agenda
		Workforce Enabler £14m	• Workforce Efficiency & Transformation (additional to individual provider savings)
		Infrastructure Enabler £27m	• Black Country Digital Strategy - £24m (ePrescribing) • One Public Estate - £3m (additional to individual provider savings)
		Future Commissioning £82m	• Strengthen collaborative commissioning to support local services • Undertake clinical service reviews of key services across the Black Country • Seek to achieve stretch target savings of £82m to enable further investment in service developments
		Addressing the Wider Determinants of Health	• Reducing the Prevalence of Long Term Conditions • Maximizing the Impact of the Health Pound
	£188m Social Care	**Local Authority Investment & Savings Plans - £188m**	• Additional BCF funding/Social Care Precept - £69m • LA efficiencies (locally defined) - £119m

1. LOCAL PLACE-BASED MODELS OF CARE

Project Lead – Paul Maubach

Project Ambition

To address the changing needs of our population with integrated care solutions that maximise the potential of the individual person, the teams that support them and the wider health and care system.

Key Actions		Milestones
1	Mapping current intentions and models in each borough to identify best practice and areas of replication to speed up implementation	Apr 2017
2	The adoption of a developmental evaluation framework will enable accelerated implementation from a robust evidence base, transferable to other STPs;	Apr 2017
3	Developing standardised access to services utilising the full benefits of the new 111 service, integrated OOH, new digital technologies and single points of access in each community;	Each area is starting from a different position. All models to be fully in place by April 2019, Dudley by Apr 2018.
4	Improving long-term conditions and care pathways with emphasis on prevention, early detection, self-care and building community resilience, supported by Integrated Care Teams working to the same outcome objectives;	
5	Creating better coordination for our frail elderly and those with complex needs through integrated place-based teams which include social care and the voluntary sector, shared records and mobile devices, community outreach services, and advanced care planning , reducing social isolation and supporting patients dying in the place of their choice;	
6	Accelerating the learning from our vanguard sites to implement new incentive and risk management models – long-term whole population budgets /contracts commissioning for outcomes;	

Key Risks & Mitigation

Sponsor sign up is a risk due to change to system incentives. Mitigation is that plans are place-based and have a degree of accountability and autonomy for implementation. CCG leadership is required and is in place in each area.
Risks around contractual obligations and procurement of new ways of working can be mitigated by learning from vanguard sites.
Securing the workforce required to change skill mix, and demand for key roles such as ANPs and GPs, is supported through workstream engagement with HEE WM, universities and providers.

Outcomes Impact

Category	Type/Scale	Timing
Better Health	• Reduction in LTC prevalence, % deaths in hospital & social isolation;	Full evaluation framework with clear benchmarks to be completed by Apr 2017
Better Care	• Improved access, coordination of care, and patient experience (incl. dying in place of choice) • Clinical outcomes improved via MDTs, & LTC care pathways • Patient experience improves through co-production & patient activation;	
Sustainability	• Reduction in emergency bed days, admissions for ACSC, use of acute beds, nursing and social care placements, reduction in elective and non-elective activity, reductions in repeat prescribing • £81m Demand reduction	

Resources Required

Transformation funding.
£34m capital investment for primary care premises and £16m capital to support service provision closer to home.
Pace of implementation in vanguard areas is dependent on continued Value Proposition funding.

Governance

Project reports to the Operational Group and Sponsor Group. Local implementation is the responsibility of CCGs working with relevant providers. Demand reduction proposals have an interdependency with the hospital collaboration work.

Dudley's new care model proposes GP led, integrated care in the community through the development of a Multi-speciality Community provider (MCP). A new approach to continuity of care; and standardising access to services will provide a return on investment as it will improve the efficiency and effectiveness of primary care; improve self-determination by the public; contain the rising demand for emergency & planned secondary care - and thus improve efficiency of the overall system.

Actions

Develop new ways of working to support the future MCP to improve

Access:

- Increase primary care access by providing same day access to our under 5s and over 75 s population;
- Telehealth pilots in two practices covering 34,500 patients;
- voluntary sector Locality Link Workers, providing access to community-based support;
- standardised access to services utilising the full benefits of the new 111 service, integrated OOH, new digital technologies and single points of access in each community;
- Standardisation and demand management of outpatient referral pathways

Support for people to live with a **Long Term Condition**:

A new 'Dudley Quality Outcomes for Health' long term conditions framework which will develop into a full-MCP outcomes framework;

Improved long-term conditions care pathways with emphasis on prevention and self-care supported by Integrated Care Teams working to the same outcome objectives;

Extended MDT's providing consultant outreach for diabetes, respiratory and mental health conditions

Better coordinated care for those with **complex care** needs:

- Successful multi-disciplinary teams across all of our 46 General Practices for patients at highest risk of admission;
- Rollout of mobile devices to all GP practices, enabling remote access to core patient systems during home visits and better coordination at MDTs;
- Extended MDT's providing consultant outreach for complex frail elderly and children with complex health needs;
- Implement the Airedale model for telemedicine support to care homes
- Implementation of a fracture liaison service;

System wide **enablers** for the above:

•An IT Local Delivery Roadmap towards integrated care records by 2020;

•scoping of services, outcomes and characteristics of the MCP; and developing the relationship between the MCP and other providers.

•Developing and implementing the system-wide solutions on complex care (including frailty); LTC management and access

•Award a contract for Dudley MCP in 2017/18 which includes :

•A meaningful outcomes framework to measure improvements in population health supported by a clear and robust evidence base, transferable to other STPs;

•Integrated place-based teams to achieve effective care coordination for a population (patient, registered with a practice, part of a community).

•Accelerate the learning from our vanguard site to implement new incentive and risk management models – long-term capitation based contracts commissioning for outcomes across the STP footprint.

•All of the above will be underpinned by on-going involvement and public consultation (where necessary) with local people.

•We will fully engage with all staff involved in the transition of the MCP.

Milestones

Dudley is an MCP national vanguard and the overarching objective is to have a fully-established MCP operational from April 2018, holding a capitation-based outcome-driven MCP contract.

In the intervening period the existing providers are collaborating to develop the MCP model of care; and are preparing to respond to the procurement to create the MCP in full.

MCP development and the implementation of the current value proposition is coordinated by our Partnership Board and led by Stephanie Cartwright.

Key timetables for development include:

- On-going development of MDTs (on-going since 2015/16)
- Full implementation of the new primary care outcomes framework - 2016/17
- Improving capabilities in the primary care at scale component of MCP - during 2016/17
- Testing LTC 'team without walls' concept across the system with - phased development through 2016-18
- System-wide new frailty pathway – phased development through 2016-18
- Establishing full MCP Patient reported outcomes 2016/17
- Implementation of the Single Point of Access – interim development of frail elderly solution in 2016/17; full implementation including full integration with NHS 111 will be post MCP procurement

The MCP procurement is led by Neill Bucktin and is working to a timetable as follows:

- Public consultation on outcomes and scope of services July-Sept 2016;
- Mapping of risks & mitigations resulting from the procurement Sept 2016;
- PIN notice issued October 2016;
- Market development on-going until Jan 2016;
- Regulator gateway 1 assurance Nov 2016;
- PQQ published Feb 2017;
- Contract Award Sept 2017;
- Full MCP mobilisation April 2018

Impacts

Better Health:

Reduction in LTC prevalence, % deaths in hospital & social isolation; increase in people with LTC feeling supported.

Better Care:

- Improved access, coordination of care, and patient experience of GP, community and other placed-based services
- Clinical outcomes will be improved via MDTs, LTC care pathways and standardising access to care
- Patient experience improves through co-production & patient activation; and by delivering more efficient & holistic care
- Safety/quality of the service will be safeguarded through standardised access and pathways; improved communication and reducing variation

Sustainability:

- Resource sustainability will be realised through changing culture and behaviours, increased efficiency and improved staff retention
- Reduction in emergency bed days, admissions for ACSC, and use of acute beds, nursing and social care placements

Potential Headline Statements

- Delivery of Rightcare opportunities will deliver a 15% reduction in Elective activity over a 4 year period
- Delivery of Rightcare opportunities will deliver a 14% reduction in Non Elective activity over a 4 year period
- Improved management of Ambulatory Care Sensitive Conditions at a Primary Care MDT level will reduce the annual number of admissions by approximately 1,000
- Improved Primary Care productivity through schemes such as online booking, EPIC programme, centralised repeat prescribing and MDT working will increase the annual GP appointments by 25,000
- Multi Disciplinary Team working will improve efficiency and increase community productivity will increase community contacts by approx. 15,000
- The development of the new front end of A&E will allow an additional 4,000 patients to be triaged and seen by a more appropriate primary care clinician
- The new MCP model will help to improve referrals and also encourage appropriate outpatient activity to be delivered in a community setting. This will reduce the number of secondary care outpatient attendances by 43,000, approximately 3% per year.

Governance and Responsibility: There is a partnership board which represents all health and care organisations across the borough to guide the development of the MCP. There is a primary care development steering group to bring Dudley GPs together and develop the future of primary care in the model. There is a procurement project board led by the CCG to make the procurement decisions on the MCP. Dudley CCG is the lead organisation and has considered conflicts of interest to ensure that we have robust separation between functions and personnel where necessary.

SWBCCG are the commissioning organisation for the Modality Vanguard MCP, the objective of which is to have a fully established MCP operational from April 2018, holding a whole population budget, subject to public consultation. Further work is being undertaken on the Transformation Area programme to scale up the new care model- with other emerging groups taking on the NCM by model by April 2019

Actions

Work has also commenced and is currently underway on

New Care Models:

- A New Care Models Project and programme plan has been established with a number of workstreams to ensure delivery of a new model for provision from April 2018 for Modality as a vanguard, with delivery from April 2019 in other areas.
- Development of existing advice and guidance services through Modality Vanguard pilot schemes e.g. Consultant Connect as a vehicle to pilot new ways of working

CCG Priorities

- Roll out of Right Care priorities for the CCG:
  - Maternity
  - Children and Young People
  - Infant mortality
  - Mental Health
  - Urgent Care
  - Cancer
  - Respiratory

By delivering new ways of working to not only reshape provision on a local level but support all future MCPs to increase

Access, Provision and Cost Efficiency:

- Standardisation of access to services through the new NHS 111 service, integrated OOH, new digital technologies and single points of access
- Implementing 7 day services, in conjunction with the PCCF
- Provision of community based services on an increasing basis, such as the recent mobilisation of direct access community diagnostic and extended minor surgery services
- Diagnosis and treatment of cancer with the use of a new Cancer work plan, to improve outcomes across all indicators.
- Positive Experience of Maternity provision by remodelling existing community midwifery services with current provider to deliver National Best Practice and working across the STP footprint on maternity and infant mortality
- Case finding and prevention in LTC, for example; active Atrial Fibrillation Case finding within practices and active lifestyle management of pre-diabetes to prevent development of Type 2 diabetes.
- Increase quality and coordination of End of Life Service provision with the mobilisation of the End of Life hub model
- Detailed mapping of existing children's community service provision to identify gaps or inequity in services
- Mental health, which is also reflected in STP mental health work plan
- Prescribing of High Cost drugs- implementation and roll-out of Blu-teq

Milestones

SWBCCG are the commissioning organisation for the Modality Vanguard MCP- the objective is to have a fully established MCP operational from April 2018, holding a whole population budget, subject to public consultation.
Further work is being undertaken on the Transformation Area programme to scale up the new care model- with other emerging groups taking on the NCM by model by April 2019

Governing Body Procurement decision during November 2016

- Baseline model in place for full scope, and Vanguard Scope- working on appropriate scope modelling with clinical support during 2016/17 and early 2017/18.
- Primary Care Commissioning Framework fully implemented for 2016/17 and updates in progress for 2017/18 to deliver enhanced primary care and access and other clinical outcomes.
- Vanguard MDT in place and SPA with outcomes measurement through the partnership board through 2016/17 and 2017/18
- MCP development and the current value proposition will be co-ordinated by the CCG partnership board and led by Claire Parker from 2016/7 onwards.
- Implementation of GP strategy to deliver preparedness for NCM- current consultation closed August 2016 with the final document due for approval during October 2016

Public consultation to start January 2017 led by SWBCCG Engagement team

Impacts

Better Health:

Reduction in LTC prevalence, % deaths in hospital & social isolation; increase in people with LTC feeling supported.

Better Care:

- Improved access, coordination of care, and patient experience of GP, community and other placed-based services, such as maternity provision and end of life care services
- Clinical outcomes will be improved via MDTs, LTC care pathways and standardising access to care
- Patient experience improves through co-production & patient activation; and by delivering more efficient care and preventative services to reduce the necessity for ongoing provision as time progresses
- Safety/quality of the service will be safeguarded through standardised access and pathways; improved communication and reducing variation

Sustainability:

- Resource sustainability will be realised through changing culture and behaviours, increased efficiency and improved staff retention
- Reduction in emergency bed days, admissions for ACSC, and use of acute beds, nursing and social care placements

Potential Headline Statements

- Delivery of Rightcare opportunities will deliver a 15% reduction in Elective activity over a 4 year period
- Delivery of Rightcare opportunities will deliver a 9% reduction in Non Elective activity over a 4 year period
- Improved management of Ambulatory Care Sensitive Conditions at a Primary Care MDT level will reduce the annual number of admissions by approximately 1,700
- Multi Disciplinary Team working will improve efficiency and increase community productivity will increase community contacts by approx. 25,000
- The development of the new front end of A&E will allow an additional 7,000 patients to be triaged and seen by a more appropriate primary care clinician

Governance and Responsibility: New Care Model Programme Board reporting to the Governing Body with decision making to be made at Primary Care Commissioning Committee which is Lay member led.

Health and care partners have established the Walsall Together Partnership to develop and implement a new Model of Care: a greater emphasis on prevention, patient activation, community resilience; creating integrated health and care services; streamlining and standardising access to services; supporting people with long term conditions; and co-ordinating care for people with complex needs.

Actions	Milestones	Impacts
Develop new ways of working to transform the efficiency and effectiveness of health and care services: • We will support citizens to develop and harness the assets in communities to further develop a prevention and early intervention offer that keeps people well and independent in their own communities. • We will simplify, integrate and standardise access to health and care services, ensuring quality and value through the commissioning of best practice pathways. • We will tackle unwarranted variation in the care and treatment of people with on-going health and care needs. • We will create integrated health and care teams, with general practice at the centre of care provision and supported by specialists working in the community, to provide multi-disciplinary co-ordinated care to people with complex health and care needs. • We will work together as system leaders to ensure that the resources and assets that we have in Walsall are most effectively deployed and have the necessary capabilities to deliver the new care model Plans for the creation of new integrated Health and Care Teams have been agreed – 7 teams, geographically aligned, covering 30k-50k populations. Community nursing re-structure complete, social care staff alignment to new structures in progress, discussion on-going re mental health team alignment. Beginning discussion also with the voluntary sector. Workshops to be held in each locality/team area, bringing together primary care, social care, community nursing, mental health to look at how the integrated teams can work differently and better for patients, drawing on learning from national Vanguard programme. Task and Finish groups to develop the Model of Care for priority areas: End of Life, Dementia, Diabetes, Health of Very Young Children, MSK and Respiratory.	Walsall Together is currently developing the Model of Care; it is anticipated that it will begin to prototype key changes early in 2017. The scope and scale of the programme is such that this will be a multi-phase development, as the implementation of different elements of the model and the roll out to full population coverage are managed over time within the overall programme. The CCG and Local Authority will need, in due course, to consider the commissioning of new models of care in the light of their legal duties, including EU and UK procurement law and, for the CCG, the Health and Social Care Act. At present, however, we believe that our models of care are not sufficiently well developed to enable commissioners to determine the approach to procurement and contracting that will ensure that the best outcomes and value is achieved. We propose therefore that there should be a further period during which we continue to work collaboratively with existing providers to develop, refine and test the model, following which a formal decision regarding the commissioning of the new model of care will be agreed. It is anticipated that the decision will be made within a timeframe that allows new arrangements for the commissioning of the new model to be in place by April 2019.	Better Health: Reduction in LTC prevalence, % deaths in hospital & social isolation; increase in people with LTC feeling supported. Better Care: • Improved access, coordination of care, and patient experience of GP, community and other placed-based services • Clinical outcomes will be improved via MDTs, LTC care pathways and standardising access to care • Patient experience improves through co-production & patient activation; and by delivering more efficient & holistic care • Safety/quality of the service will be safeguarded through standardised access and pathways; improved communication and reducing variation Sustainability: • Resource sustainability will be realised through changing culture and behaviours, increased efficiency and improved staff retention • Reduction in emergency bed days, admissions for ACSC, and use of acute beds, nursing and social care placements

Governance and Responsibility: Development of Walsall Model of Care and implementation system-wide transformation programme is managed through the Walsall Together Partnership.

Wolverhampton's Primary Care Strategy is underpinned primarily by delivery through a Multi Speciality Community Provider (MCP) delivered by care hubs who are supported by integrated teams and through a Primary and Acute Care System (PACS).
The introduction of care hubs will enable the new care model to deliver improved access, improved care co-ordination and continuity of care in the community whereby care can be provided closer to home and in the community setting as far as reasonably practical.

Actions

Develop new ways of working at hub level supported by integrated teams as the MCP evolves:-

Access:

- Implement training for care navigators intercept & guide patients to the health & social care professional that best meets their needs whilst maximising social prescribing opportunities at practice level too ***March 2017***
- Improve access to services based in primary care including direct access to diagnostics identified through peer review, patient choice and shared decision making. Access to a full range of standard primary medical services during core hours and essential services 24 hours a day 7 days a week through a combination of primary care and extended out of hours service provision with access to central patient records and where feasible non face to face consultations using skype, email, telephone etc ***September 2017***
- Strengthen access to services utilising the full benefits of the new 111 service, integrated OOH, new digital technologies and single points of access ***December 2017***

Care Co-ordination:

- Develop home based care including provision of hospital at home, community intermediate care, reablement, rapid response, therapy services and support from the third sector ***March 2017***
- Implementation of local strategies for Intermediate Care, End of Life, Ambulatory Care, Mental Health and Primary Care to maximise opportunities for place based care ***September 2017***
- Extended MDT's providing consultant outreach for diabetes, respiratory, mental health conditions initially, extending a broader range of disease conditions by ***April 2019***

Continuity:

- Ensure appropriate & timely support in line with our Integrated Care Strategy to support hospital discharge, prevent admission to hospital, avert potential care home admission, identify support that is suitable to meet the needs of individuals ***October 2016***
- Reduce demand on services traditionally provided in a hospital setting and provision of alternatives to out-patient appointments to improve waiting times, diagnosis & treatment achieved through shared decision making, advice and guidance and patient choice ***March 2018***
- Improved long-term conditions care pathways with emphasis on prevention and self-care supported by Integrated Care Teams who are striving to achieve the same outcomes ***March 2018***

Practices as Providers & Commissioners

- Practices working together at scale with community neighbourhood teams that ensure coverage across the city for patients at highest risk of admission to hospital ***March 2017***
- Develop and implement a local Quality Outcomes Framework that seeks to achieve the highest standards of care quality, value for money & maximises opportunities for groups of practices to work at scale ***March 2017***

Milestones

The Primary Care Strategy in Wolverhampton spans an implementation timescale of ***4 years 2016 to 2020.***

Practices have begun to work at scale and will be commissioned at scale to deliver improved Access from ***April 2017→*** with a trajectory to improve access using a range of sources by ***December 2017.***

The achievements of our care hubs are monitored closely by the Primary Care Strategy Committee and Governing Body as well as the city's Health & Wellbeing Board ***October 2016→***

Support the PACs (Primary and Acute Care) Model and MCP (Multi Speciality Care Provider) to develop & sustain general practice through working at scale in line with both frameworks to ensure the most appropriate delivery model is adopted ***April 2017***

Our new strategies are being implemented across the city and will result in patients receiving care co-ordinated by their GP Practice working in close collaboration with their Community Neighbourhood Team with anticipated implementation by ***September 2017***

Identification, work up and launch of extended MDT's to reduce demand on service and improve long term condition management will be realised fully by ***April 2019***

Impacts

Better Health:
Reduction in long term condition prevalence, deaths in hospital & social isolation; increase in people with long term conditions feeling supported with care closer to home.

Better Care:

- Improved access, coordination and continuity of care resulting in positive experiences of care in primary, community and other placed-based services
- Timely availability of a range of services at hub level 7 days a week that enable care co-ordination and continuity
- Improved Clinical outcomes as a result of practice groups, neighbourhood teams and other specialists working cohesively to provide patient centred care particularly for those with long term conditions & in greater need of support
- Continuous improvement in service development and provision through engagement with patients who have co-produced efficient & holistic care
- Reduced variation to improve care quality as a result of standardised pathways; improved communication across our practice groups

Sustainability:

- Resource sustainability will be realised through implementation of the CCGs Primary Care Strategy. This will realise improvements in practice service provision, commissioning at scale, workforce, estate, IT, contracting and resilience within each group of practices.
- Reduction in emergency bed days, admissions to hospital and use of acute beds, nursing and social care placements
- A range of healthcare professionals providing timely intervention delivering the best possible care in the most effective way.

Deliverability:

- Responding to opportunities for improved care quality for pathways included in the Rightcare Programme will realise improved clinical effectiveness
- Improved management of patients during their end of life phase
- Improved Primary Care productivity & efficiency through full implementation of a range of IT schemes that enable online booking, online consultations, centralised repeat prescribing and hub working with supporting integrated teams

Governance and Responsibility: There is a Transformation Board with representatives from all health and care organisations across the city to guide the development of the MCP.
There is a Primary Care Strategy Committee focussed on implementation of the Primary Care Strategy and realisation of the MCP Framework that meets the needs of our population.

2. EFFICIENCY AT SCALE THROUGH EXTENDED HOSPITAL COLLABORATION

Project Lead – Toby Lewis

Project Ambition

To deliver a scale of efficiency beyond the reach of individual providers through coordinated action to develop networked and/or consolidated models of secondary care provision.

Key Actions		Milestones
1	Develop shared/single service plans for acute specialities with particular opportunities/challenges	
2	Develop new models of care to support specialised services incl cancer/vascular	
3	Develop options for delivering efficiency in pathology services	Q2 2017/18
4	Extending collaboration in back office services	
5	Complete MMH development	Q3 2018/19
6	Commission for Quality in Care Homes	
7	Delivery individual CIPs	Annual

Key Risks & Mitigation

Outcomes Impact

Category	Type/Scale	Timing
Better Health		
Better Care	• Reduced variation in care and improved outcomes	
Sustainability	• Delivery of >2% CIPs • £189m net savings (excluding additional workforce and infrastructure savings)	

Resources Required

£35m capital to support any premises changes required to deliver networked models of care.

£3m capital allocated to enable £10m annual revenue savings relating to estates efficiencies as part of CIPs.

Governance

- Project reports to the Operational Group and Sponsor Group. There is also a reporting line to the Black Country Alliance. Project includes DGFT, RWT, SWBH & WHT. There is an interdependency with demand reduction proposals/local place-based models, and also with demand assumptions of neighbouring STPs.

3. IMPROVING MENTAL HEALTH & LEARNING DISABILITIES SERVICES

Project Lead – Steven Marshall

Project Ambition

Our ambition is to give people living with all types of mental health and learning disability challenges, better outcomes and better services across the Black Country. We will deliver this improvement by reducing the variation in services people receive, standardise our approach to commissioning and use the resources we have in the Black Country as a whole, better - including reducing the need for people to go out of area. By coming together as both commissioners and providers, we can build on mental health wellbeing

	Key Actions	Milestones
1	**Become One Commissioner** Co design, agree and deliver a pathway based suite of designed and specified services (CAMHS; Planned; Urgent; Functional Older Adults) common to all 4 areas of the STP footprint	April 2018
2	**Build the Right Support for Learning Disabilities** • Review and redesign community pathways for supporting people • Review and redesign inpatient services in line with the national • Deliver targeted workforce, provider and family training to support new models of care Develop the market to encourage robust provision, and increase the uptake of personal budgets Develop key dashboard reporting tool across TCP Align budgets from NHSE to redirect into CCG-commissioned services, in preparation for shadow budgets 2018/19	 Q1 2017/18 Q4 2017/18 Q4 2017/18 Q4 2018/19 Q3 2016/17 Q4 2016/17
3	**Improve Bed Utilisation and Stop Out of Area Treatments** • Baseline assessment of bed usage across the Black Country (both Acute overspill and specialist beds); Provider benchmarking review • Improved capacity management within CCG and Provider functions • Review of Urgent Care Pathway across Black Country and implementation of 5YFV recommendations • Explore the potential for bed reconfiguration as part of TCT • Merge Project with Gap Analysis on specialist bed provision to identify Black County based solutions.	 Q4 2016/17 Q1 2017/18 Q2 2017/18 Q3 2018/19 Q4 2019/20
4	**Deliver the Combined Authority Mental Health Challenges** • Implement and deliver Mental Health Waiting Times and Access Standards • Develop and implement a targeted demand reduction plan (incl. substance misuse/suicides & homicides; and addressing wider determinants e.g. MH supported Housing • Develop and implement an All Age Black Country Primary Care Mental Health Strategy • Develop and Implement an All Age Black Country Suicide Prevention Strategy • Develop and implement a Support into Employment Service (IPS) including support post-prison reintegration • Develop, pilot, implement and evaluate provision of 'Mental Health First Aid' training	 Q4 2017/18 Q2 2017/18 Q4 2017/18 Q4 2017/18 Q1 2017/18 Q3 2017/18
5	**Deliver extended efficiencies through TCT partnership** • Mobilise work streams • Feedback from work streams/Review of project proposals by Oversight group • Development of project business cases • Implementation of approved projects	 Q2 2016/17 Q3 2016/17 Q3/4 2016/17 Q1 2017/18 ➔

3. IMPROVING MENTAL HEALTH & LEARNING DISABILITIES SERVICES

Project Lead – Steven Marshall

Outcomes Impact

Category	Type/Scale	Timing
Better Health	Improved access to mental health and mental well-being initiatives, care pathways and services across the life span, reducing levels of complexity and chronicity including physical ill health and improving quality of life and life chances and opportunities.	2017/18
Better Care	Improved access to health and social care driven initiatives across all statutory and non-statutory key stakeholder partners and agencies, aligned with WMCA MH Commission deliverables including focus on primary care and also mental well-being and the wider determinants of mental ill-health in individuals, families and communities.	2018/19
Sustainability	£20m net savings. Transformed outcomes and experience and reducing demand of high levels and types of need on mental and physical health secondary and tertiary services, optimising recovery and developing and delivering initiatives to increase capability in Primary Care and Third and Voluntary Sector Services.	2020/21

Resources Required

Non-recurrent investment will be required to support delivery of the transformation. £10m has been allocated to enable the estates changes linked to service transformation.

In addition, dedicated programme support will be required in order to ensure the programmes are delivered on time and in full.

Key Risks & Mitigation

Alongside each works stream specific risk there are two overarching risks:

1. The scale and timing of benefits across the Triple Aim will be reduced if all partners are not fully engaged and committed to a collaborative approach to delivering the maximum benefits for the Black Country population. This is being mitigated through on-going partnership working, which ensures patient outcomes remain firmly at the heart of decision making.

2. The creation of a new MCP vanguard within the footprint could result in a non aligned commissioning model and the provision from an alternative non BC provider (financial sustainability is not mitigated). Mitigated through GP engagement ensuring new MCP services and specs are aligned with the STP (or vice versa).

Governance

- Project reports to the Operational Group and Sponsor Group. There is also a reporting line to the TCT partnership. Project includes 4 CCGs plus DWMHT, BCHT, BCPT.

4. IMPROVING MATERNAL & INFANT HEALTH

Project Lead – Richard Kirby

Project Ambition

To achieve a sustainable model of maternal and neonatal care, improving outcomes for mothers and babies across the Black Country

Key Actions		Milestones
1	Implement the recommendations of the Cumberledge report	Q3 2017/18
2	Develop an STP-wide network for sharing intelligence and best practice on maternal, neonatal and infant health	Q1 2017/18
3	Develop a Black Country Healthy preconception and pregnancy pathway that addresses risk factors associated with poor maternal, infant and child health outcomes	Q3 2017/18
4	Identify opportunities for system wide action on the wider determinants of health	Q3 2017/18
5	Model maternity capacity projections across the Black Country and develop options for delivery	Q2 2017/18
6	Ensure best practice arrangements for birth agenda, improving maternity safety outcomes across the Black Country.	Q4 2017/18

Key Risks & Mitigation

Clinical input – Identified system leads engaged
Unsuccessful bid application- Maternal mental health innovation bid
Interdependency with West Mids regional neo natal review – Review recommendations
Future workforce capacity – Represented on LWAG
Co-design of revised pathways lacks patient engagement- ensure effective engagement strategy is in place.

Outcomes Impact

Category	Type/Scale	Timing
Better Health	Improved maternal health and infant mortality outcomes	2018/19
Better Care	Sustainable options for future delivery of standardised care; Reflective of national direction - Better Births: access, choice and empowerment	2018/19
Sustainability	Effective pre-conception care; Healthy pregnancy pathway; Neo-natal pathway ; Normalisation agenda for delivery	2018/19

Resources Required

Project Management
Clinician time and meeting attendance
Data analysis
Financial analysis

Governance

- Project reports to the Operational Group and Sponsor Group. There is an interdependency with the West Midlands Neonatal Review.

5. WORKFORCE

Project Lead – tbc

Project Ambition

To ensure that we provide the workforce, now and in the future, that can ensure patients receive safe, sustainable, high quality care in the right place and at the right time.

Key Actions		Milestones
1	STP project leads to work with the LWAB on identified workforce implications to deliver transformation	Current and ongoing
2	Scoping of new and existing workforce hotspot areas across the system and LWAB system task and finish groups to deliver the solutions	Nov 16 onwards
3	Develop a robust methodology for workforce planning across the system	2017/18
4	Development and delivery of a work plan on the priorities identified by the LWAB from the STP and Human Resources perspective. Bank and Agency spend/skill mix of workforce/integrated, sustainable and effective workforce/recruitment and retention of the workforce	Nov 16 onwards
5	Understand the Carer and Volunteers workforce to identify good practice and make recommendations on areas for development.	2017/18

Key Risks & Mitigation

The changing landscape of the workforce availability – aging workforce, generation XYZ. LWAB to understand all workforce data
Service demands – 7 day services, care closer to home, TCT etc. From workforce plans
Reduced funding – apprenticeship levy, living wage increase, changes to LBR, tariff – LWAB to explore other funding sources
Possible changes in terms and conditions with new care models . LWAB to understand implications
The system must find ways of working together on matters of consistency ie recruitment and retention, negotiated band/agency costs, workforce planning – LWAB to support
Engagement across the system – Utilise the LWAB to support this.

Outcomes Impact

Category	Type/Scale	Timing
Better Health	Reduced reliance on non-substantive staff will improve consistency of service	2017/18
Better Care	Skill mix will deliver competent care, in right place by right person.	Q4 2016/17 on
Sustainability	£14m at-scale savings beyond standard Cost Improvement Programmes. There will be a reduction in bank/agency costs, a different skill mix and a reduction in recruitment and retention costs. The transformation being developed will deliver a sustainable and flexible workforce for the future delivery of health and care provision.	2017/18

Resources Required

This is not fully clear yet. Part of the ongoing work with the STP Project Leads and LWAB will be to identify the resources required.

Governance

- This project reports to the Operational Group and Sponsor Group. It is materially dependent on the work of other transformation groups for the definition of models of care and associated workforce requirements. Its work will be enabled through the Local Workforce Action Board.

7. INFRASTRUCTURE

Project Lead – Tony Gallagher

Project Ambition

To ensure the STP has a sustainable infrastructure (One Public Estate and Digital) that supports transformation of care models.

Key Actions		Milestones
1	Explore potential to buy-out elements of PFI or Lift	Q3 2017/18
2	Review utilisation of current public estate and develop options for more efficient usage	Review to be completed by Q4 2016-17 with options to be developed by Q3 2017/18
3	Form Black Country Digital Transformation Board to lead, drive & own delivery of Local Digital Roadmaps	• Well established BC LDR Group - complete • Ratify MOU and ToR – Q3 16/17
4	Develop Digital Delivery Plans to take us from current state (16/17) to digitally enabled state (17/18) to connected state (18/19) to integrated state (19/20)	• Develop agreed digital architecture – Q4 2016/17 • Develop phased digital plan including interoperability, empowerment, intelligence, infrastructure) – Q1 17/18 • Deliver digital plan Q1 17/18 – Q4 19/20 • Paper free - Q4 19/20
5	Accelerate & support extant plans within organisation & LDR footprints, ensure one direction, avoid duplication, minimise 'risk of regret' & maximise triple aim benefits	• Well established BC LDR Group – complete • Develop risk register – Q3 16/17 • Finalise governance - Q3 16/17 • Shared Learning - Q3 16/17 • Benefit realisation - Q3 16/17 to Q4 19/20 • Vanguards - TBC • ETTF funded integration within LDR's Q4 16/17
6	Rapidly identify & deliver 'quick wins' such as ePrescribing, ToC (electronic correspondence), network rationalisation, and procurement efficiencies	• Agree strategy to deliver integrated roadmap – Q4 16/17 • ePrescribing – Q4 17/18 • Network rationalisation e.g. HSCN (plan) – Q4 16/17 • Procurement Efficiencies Q4 16/17 – Q1 19/20

Key Risks & Mitigation

Estates:
Access specialist advice and renegotiation of existing contractual arrangements.
Usage options linked to Transformation plans.
Digital:
Alignment of collaboration – strong leadership, transparency, geographical implications, cross boundary patient flow .
Funding – at scale procurements, shared learning, willingness to implement change to forward 5YFV.
Development of Digital Culture – shared learning, strong leadership, transparency, good communication.
Variance in digital maturity (technologically and culturally) – planning, accurate baselines.
Feasibility of technology vendors offering solutions to benefit all health and care services within existing portfolio, without requiring bespoke development – Effective development of requirement specifications and standards. Effective procurement processes.
Existing locality contract values of existing solution may be superseded through preferred shared solutions – planning, transparency, strong collaboration, working with NHSE, Head of Digital Technology.
Gaining buy in [providers and patients] to share information across the Black Country – Communication, established group approach, governance, shared learning from peer organisations.
Organisational change impact is workforce efficiency – effective change management/communication.

Outcomes Impact

Category	Type/Scale	Timing
Better Care	Delivery of solutions to support new care models	2020/21
Sustainability	Savings from ePrescribing (£24m). Additional reduction in STP estates costs (£3m).	2020/21

Resources Required

Specialist advice.
Capital funding - £5m to support implementation of ePrescribing.

Governance

- This project reports to the Operational Group and Sponsor Group. It is dependent on the work of other transformation groups for the definition of requirements.

8. FUTURE COMMISSIONING

Project Lead – Andy Williams

Project Ambition

To simplify and standardise commissioning mechanisms across the Black Country in order to support Better Health and Better Care, and to remove duplicated costs.

Key Actions		Milestones
1	Identify priority areas for streamlining and standardisation – both quick wins and major opportunities – via Clinical Reference Group	April 2017
2	Strengthen collaborative commissioning between CCGs and Local Authorities on a place-based basis	Ongoing
3	Undertake clinically led service reviews (informed by Senate Assurance framework)	December 2018
4	Identify and evaluate alternative mechanisms (including new contracts types and organisational forms) through which streamlining and standardisation can best be enabled, and efficiencies delivered	April 2018
5	New commissioning arrangement s to be implemented and relationship with regulators to be confirmed	April 2019 (Dudley Apr 18)
6	Assess system-wide impact of MMH and develop plans in response (as required)	April 2017
7	Seek to achieve stretch target savings of £82m to enable further investment in service developments	Ongoing

Key Risks & Mitigation

1. Learning from local vanguards and others pilots is not maximised. We are seeking to develop a learning framework to ensure lessons from our innovations are learnt rapidly and effectively across the Black Country.
2. New contractual models are delayed or do not support delivery of improved outcomes. A range of models will be explored and tested, and we are actively engaged in the development of a national assurance framework for new contract types.
3. Difficulty in securing new commissioning skills and capabilities. Workstream to identify skills and capabilities required, and align HR/OD processes accordingly.

Outcomes Impact

Category	Type/Scale	Timing
Better Health	Reduction in unwarranted variation in service outcomes	2019/20
Better Care	Less complex and more effective models of care	2019/20
Sustainability	More efficient service delivery and removal of duplicated commissioning costs. Services at risk due to workforce challenges are retained in the Black Country	2019/20

Resources Required

- Clinician time for leading review processes
- Engagement of Local Authority partners and NHS regulators
- Evidence analysis and analytical modelling to support clinical reviews
- Support for public engagement in service reviews

Governance

This project reports to the Operational Group and Sponsor Group. There are critical interdependencies with CCG decision-making and NHSE specialised commissioning.

9. ADDRESSING THE WIDER DETERMINANTS OF HEALTH

Link to WMCA – Sarah Norman

Project Ambition

To take effective and coordinated action with LA partners (including the WMCA) through a focus on the wider determinants of health to support people live healthier longer lives.

Key Risks & Mitigation

To be identified as plans for each key action are developed.

Key Actions		Milestones
1	Develop and implement a range of evidence-based recommendations that support the whole prevention agenda and what that means across the health and social care system.	Completion of local preventions/ early intervention framework.
2	Implement the recommendations of the Mental Health Commission once published.	Plan developed.
3	Deliver ambitious programmes across the Black Country to address key lifestyle risk factors, mobilising health and social care systems to deliver Making Every Contact Count and mental health literacy. This will include the implementation of workplace health and wellbeing programmes across all health and social care sectors including local business.	Adoption of NHS Healthy Workforce Programme and associated CQUIN/ Workplace Wellbeing Charter (PHE).
4	Develop STP-wide network of best practice. Identify prevention resources /self-help tools.	Collection of case studies
5	Work across health and social care system including the WMCA to build social capital and improve resilience: reduce social isolation; promote independence through personalisation; develop place-based models of care to improve management of LTC; improve employability and skills development to make an impact on productivity; and encourage a wellbeing focus across all health, social care and spatial planning policies.	Mapping of community resources

Outcomes Impact

Category	Type/Scale	Timing
Better Health	Bridges the divide between population change and individual behaviour change to scale up ill health prevention to improve healthy life expectancy and mental wellbeing.	2020/21
Better Care	Supports investment in a preventative approach across the system that should impact on health inequalities and reduce avoidable hospital admissions	2020/21
Sustainability	Large scale implementation of a preventative approach should provide clarity on the return on investment from a health, social and financial perspective leading to sustained investment.	2020/21

Resources Required

Local Public Health departments working together with WMCA and STP workstreams.

Governance

This work links the work of the Sponsor Group with the 5 Local Authorities and the West Midlands Combined Authority.

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY MEETING – PUBLIC SESSION

13 DECEMBER 2016

Agenda item 11

Title of Report:	**The potential future of commissioning across the Black County**
Report of:	Trisha Curran – Interim Chief Officer
Contact:	Trisha Curran – Interim Chief Officer
Governing Body Action Required:	To agree the recommendations summarised below.
Purpose of Report:	Following a meeting of the AOs across the Black Country in October it was agreed that a single version of a paper would be taken to each of the four CCG Governing Bodies to discuss potential future commissioning arrangements. The objective is to establish, if possible, a common consensus for collaboration between the four CCGs. The attached paper was taken to each of the four Governing Bodies in November 2016. Our GB received it in private session as staff had not yet been briefed on the content and we wished to avoid unnecessary anxiety. **At its meeting in November the Governing Body agreed the recommendation that *"each of the four CCG Accountable Officers and Chairs be tasked to work together to produce a detailed proposal; including a staff engagement plan; on the detail of these arrangements for approval by each Governing Body*".** Staff have subsequently been fully briefed and are aware that this does not change the CCG's statutory duties or considerable local (Wolverhampton) place-based agenda.

	RECOMMENDATIONS: The Governing Body is asked to; 1. **Receive** this report and attachment in public session. 2. **Note** that the potential collaboration of any commissioning functions will not cede sovereignty of any funds or obviate the statutory duties of the CCG. 3. **Note** that CCG staff have been briefed on the contents of this paper and will be kept updated on discussions. 4. **Agree** to receive further updates on any proposals about future commissioning as they develop.
Public or Private:	Public session
Relevance to CCG Priority:	This document is material to all of the CCG's priorities and nothing contained within the attached report is contrary to those priorities.
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 is material to all of the current domains within the CCG BAF.

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**	**01/12/16**

1. BACKGROUND AND CURRENT SITUATION

1.1 Planning Guidance for 2017/18 - 2018/19

1.2 The current planning guidance requires us to establish 2 year contracts through to April 2019 and for contract negotiations to be concluded by Christmas 2016.

1.3 However, once these negotiations are concluded, this offers the potential for some breathing space, to enable our CCGs to restructure and/or establish new collaborative arrangements; set clear strategic priorities; and undertake any necessary reviews / preparatory work prior to establishing contracts post April 2019.

1.4 The suggestion is that the four CCGs should give serious consideration to how they collectively might best maximise our potential for the future by establishing new working arrangements that take best advantage of the skills and capabilities of our teams; and also enhance our capabilities where needed.

2. Statutory Responsibilities

2.1 There are no statutory mechanisms for merging CCGs; and each CCG has to continue to fulfil its own statutory responsibilities – so, for the sake of clarity, a merger of CCGs is not an option to consider.

3. Current Collaboration

3.1 Our current CCGs already collaborate as part of a wider group on the commissioning of WMAS and NHS111.

3.2 We have also collaborated in the development of the STP and on the work streams within that – noticeably on Mental Health, Maternity and local placed-based delivery. However none of these arrangements incorporate shared decision-making or shared commissioning resource.

4. BLACK COUNTRY STP

4.1 The latest version of the STP includes a section on the potential future commissioning arrangements for the Black Country.

4.2 The future shape of service commissioning within and across the Black Country needs to be aligned with the evolving nature of service provision. What is set out here reflects initial exploratory work by a number of our commissioning bodies. We will now test and refine our approach with all our commissioning partners.

4.3 The Black Country is currently served by ten commissioning organisations across health and social care; this is likely to lead to:

- Duplication of activity and cost;
- Unnecessary complexity in models of care and in commissioning procedures (including procurement);
- Unwarranted variation in service delivery and outcomes.

4.4 Working together within the STP presents us with real opportunities to address these challenges and to look more strategically at the provision of services across the Black Country, including how they interact with services in neighbouring areas. This work will be led through an STP commissioner group including NHS and Local Authority partners.

4.5 New ways of working together as commissioners are required to support the delivery of our local Accountable Care Organisation models, so we aim to simplify and standardise commissioning mechanisms across the Black Country in order to support Better Health and Better Care, and to remove duplicated costs by:

- Identifying priority areas for streamlining and standardisation – both quick wins and major opportunities; and
- Identifying and evaluating alternative mechanisms through which streamlining and standardisation can best be enabled.

4.6 The current NHS planning guidance requires NHS commissioners to agree two-year contracts with providers for 2017/19. This will not only create some medium-term stability for the system but will also afford the opportunity to review our commissioning arrangements in preparation for commissioning services for beyond April 2019.

4.7 The Black Country STP sets out two main structures for the delivery of health and social care transformation across the Black Country:

a) Local Place-based Delivery of Care

This includes the implementation of the new care models such as the Multispecialty Community Provider (MCP) models in West Birmingham (Modality) and in Dudley Wolverhampton has implemented the Primary Care Home (PCH) model across the majority of practices and has also a Primary and Acute Care System (PACS) type model with the remainder of its

practices. As set out above, each of our local areas will have its own locally-appropriate model for delivering place-based care.

b) Extended Provider Collaboration

This includes the MERIT vanguard and Transforming Care Together Partnership for mental health services, and collaboration on service delivery and support services between the Trusts running our four acute hospitals.

4.8 There is, therefore, a clear benefit in organising commissioning arrangements across the Black Country to enable and enhance the implementation of these two complementary strands. Further consideration also needs to be given to the consequential impact on CCGs once the new models of care have been fully commissioned.

4.9 The key considerations for each of these issues are set out below, reflecting our core principles of subsidiarity and collective added value.

5. Local Place-based Commissioning

5.1 Each local place-based model shares key characteristics on the need for local public accountability, supporting local community resilience and public health and wellbeing, and the integration of health and social care. Commissioning local place-based care is therefore built on a foundation of partnership working between respective Local Authorities (LAs) and Clinical Commissioning Groups (CCGs). Each local system within the STP will continue to strengthen these partnerships as the basis for commissioning the local placed-based model.

5.2 Despite existing contractual arrangements and restrictions leading to services generally being commissioned independently from each other (and often without the right incentives to deliver the agreed model of care), current service delivery is largely being implemented through collaboration between providers and commissioners. To fully support providers in achieving the desired outcomes, however, it will be necessary to change future contracts. This will most likely include moving to Whole Population Based (WPB) arrangements that focus on the achievement of improved outcomes for patients in a local area. This represents a significant change from the current contracts, particularly in health services, that are largely based on activity measures for different items of service.

5.3 NHS England has recently issued new frameworks for new models of care, including MCPs and PACS models. These frameworks will subsequently lead to the development of new national contractual frameworks which will enable us to commission local services in a way that supports the preferred model of care. There

are some common principles to these new frameworks, regardless of which model is adopted, and these give a clear emphasis on local population delivery and a priority on achieving improvements in outcomes. It will therefore be desirable to implement these new forms of contracts from April 2019. There is already active engagement in supporting the development of these new contractual models, providing two of the six national test sites via the Dudley and West Birmingham MCPs, and the development of the Primary Care Home and Chambers across Wolverhampton, and the PACs model at RWT. This creates a further opportunity to use local learning to establish a shared understanding and capability across Black Country CCGs so that, subject to local determination on timing and methodology, we are able to progressively implement these new contractual models in each local system from April 2019.

6. Black Country System-wide Commissioning

6.1 Earlier sections of our plan set out a clear need for collaboration between our acute service providers. In addition, our Clinical Reference Group (CRG) has reviewed the national Right Care evidence and determined that there are a number of services which would benefit from a strategic clinical review in order to determine the model of service delivery best placed to optimise patient outcomes, the quality of care, and efficiency in service delivery. Those services include:

- Cardiovascular Disease (e.g. heart attacks, stroke);
- Endocrine conditions (e.g. Diabetes)
- Genito-urinary conditions (e.g. Chronic Kidney Disease)
- Musculoskeletal conditions (e.g. hip replacement); and
- Cancer.

6.2 Our shared objective is to commission acute service delivery so that everyone across the Black Country can be assured that they will receive the same high quality standard of care regardless of which local hospital they attend. Consequently it will be important for the Black Country CCGs to collaborate in commissioning these services to the same standards, particularly as our providers are themselves increasingly collaborating on service delivery. This approach will also help to provide a collective commissioning approach to the realisation of efficiencies across our system.

6.3 The first stage in this process would be to initiate the proposed clinically-led strategic review. This would be followed by establishing a shared approach to commissioning those services across the four Black Country CCGs, so that from April 2019 the services can be commissioned through a single shared process across the whole of

the Black Country. The review process is expected to begin in early 2017 and is likely to be an iterative process (see diagram below).

6.4 In addition to our local-initiated work, NHSE Midlands and East's Specialised Commissioning Strategic Framework develops a vision to deliver services such as chemotherapy and renal dialysis through networks of provision based around larger specialist providers supporting local services. Specialised Commissioning teams will be working with providers and STPs to identify opportunities for consolidating services and developing networks. In the Midlands and East region, the larger specialist providers can be categorised into two tiers:

- Tier 1 providers are those that have a large and diverse specialised commissioning portfolio and provide a number of level 1 national services; and
- Tier 2 providers are those which have a large and diverse specialised commissioning portfolio and are a sub-regional specialised centre for a number of services, or a Major Trauma Centre.

7. OUR CLINICAL REVIEW PROCESS

7.1 Although a substantial range of specialist services are provided in Black Country hospitals, there are no resident Tier 1 providers (patients travel to Birmingham hospitals) and the Royal Wolverhampton NHS Trust is the only Tier 2 provider. This creates the need for a network of acute collaboration across the Black Country. The framework specifies 36 specialised services which could be devolved through the West Midlands Specialised commissioning board to a Black Country commissioning footprint.

7.2 Key drivers for commissioning at greater scale include where:

- Outcomes could be improved through service consolidation (e.g. to secure the appropriate clinical competencies)
- Services have interdependencies with other STP footprints (e.g. the configuration of specialist networks including emergency services, trauma care, PPCI)
- Services may not be sustainable as separate local entities (e.g. due to workforce shortage and/or high agency costs)
- Equity of access to high quality care can be improved.

7.3 This offers the opportunity to align a Black Country wide CCG shared approach to commissioning acute services with the specialised services framework for commissioning through our local Tier 2 provider to create an integrated Black

Country approach to the commissioning of all major acute services. Our intention would therefore be to work with NHS England to create a joint capacity and capability to commission all of these services from April 2019 on the basis of a single acute network of provision across the Black Country working to the same standards of care.

7.4 This work will also include an assessment of the potential impact of the Midland Metropolitan Hospital across the Black Country and, where necessary, the development of plans to address any adverse impact.

8. IMPACT OF NEW CARE MODEL IMPLEMENTATION

8.1 One aspect of the new care models programme is the opportunity for providers to take on responsibility for providing care to a whole population (e.g. through 'accountable care' type arrangements or Whole Population Budgets). This raises questions about the opportunities for CCGs to contract out some of their functions to providers in a way not possible before. Whilst the details on what is appropriate will be different for each local system and will be dependent upon the preferred model of care, each CCG Governing Body and its constituent members will need to consider the potential benefits this offers for enhancing the capabilities of local providers and the implementation of the new care models to drive better outcomes and efficiency.

8.2 As we move towards outcomes based commissioning and contracting which these new care models afford, the skills and capabilities of commissioners will also need to change. As the component parts of the commissioning system of the STP are addressing these challenges at different paces and with differing timescales, there exists the opportunity for greater collaboration between CCGs to facilitate and accelerate the adoption of new models.

8.3 As CCGs evolve to maximise their future effectiveness, it will also be important to consider opportunities for integration of some functions with the regulators, particularly NHS England and the Care Quality Commission, such as service assurance activities. As well as supporting the standardisation of care and the resulting improvement in patient outcomes, this may also enable additional cost savings through a reduction in the tiers of performance management and assurance processes.

8.4 A key area in which local commissioners have already been actively collaborating is in relation to urgent and emergency care.

9. Local placed-based care

9.1 Each CCG will need to continue to engage in its own planning and development of its own placed-based delivery model. And in particular, will need to collaborate with its local council on this work. So there are aspects of each CCG's activities that it will need to be fully retained in each CCG; and there will be aspects of CCG's work which they may wish to improve through enhanced collaboration with their local council.

9.2 However, there are areas relating to local placed-based delivery where common approaches across CCGs would be helpful, such as:

- Taking advantage of the new contracts, when they become available, to properly incentivise delivery of the local model of care between providers.
- Sharing understanding and solutions on the impact of social care in a system;
- The skills and knowledge being developed to implement the new capitation/outcome-based contracts (regardless of the preferred organisational forms);
- Determining the boundary between local placed-based models and the services which would benefit from Black Country-wide integration

9.3 Black Country wide joint working

9.4 Our current arrangements involve little joint resources or decision-making and as a consequence we are not leveraging or steering any significant change from our providers. So it is clear from the current financial challenges that we all face that we need to improve our impact.

9.5 There are some obvious benefits to adopting a more formalised joint arrangement for commissioning some of our services at scale across the Black Country:

- Ensuring consistent standards of delivery in key services, such as Maternity and Mental Health;
- Maximising the benefits of the 'devolution' of specialised services commissioning;
- Sharing our skills and capabilities to realise the maximum possible benefits from our providers;
- Ensuring we can oversee and incentivise the collaboration that we require from our providers.

10 RECOMMENDATIONS

The four CCG governing bodies are being asked to consider the following: **and AGREE that;**

10.1 After the current contract negotiations there would be substantial benefit in establishing more formalised collaborative commissioning arrangements across the four Black Country CCGs.

10.2 Because each CCG must retain its own statutory functions and because there is a considerable local placed-based agenda; it is preferable for each CCG to retain their own Accountable Officer for the foreseeable future.

10.3 The four CCGs should formalise (after this year's contract negotiations) the existing collaborations on the strategic clinical review of services; mental health and maternity.

10.4 The four CCGs should seek to establish a joint commissioning arrangement for acute and specialised services commissioning.

10.5 The four CCGs should seek to establish formal arrangements for sharing expertise in other relevant areas.

10.6 The CCG Accountable Officers and Chairs be tasked by the Governing Bodies to work together to produce a detailed proposal; including a staff engagement plan; on the detail of these arrangements for approval by each Governing Body.

The Governing Body is ASKED TO;

10.7 **Receive** and **note** this report.

10.8 **Discuss** its contents and raise any issues of concern to be fed back to the three other CCGs in the Black Country and their respective Governing Bodies.

10.9 **Comment** on each of the recommendations contained in 10.1 – 10.6

10.10 **Note** that the potential collaboration of any commissioning functions will not cede sovereignty of any funds or obviate the statutory duties of the CCG.

10.11 **Note** that there is a GB development session on 22 November 2016 when colleagues may wish to discuss this paper further after a period of reflection.

10.12 **Agree** to receive further updates on any proposals about future commissioning as they develop.

10.13 **Note** that these proposals will be of potential concern to staff requiring sensitive handling.

Trisha Curran
Interim Chief Officer
31 October 2016

WOLVERHAMPTON CCG

Public Governing Body 13th December

Agenda item 12

Title of Report:	**New Models of Care**
Report of:	Steven Marshall
Contact:	Steven Marshall
Governing Body Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To keep the GB appraised of the status of the development and forward action plan for the development of New Models of Care
Public or Private:	This Report is intended for the public
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	The CCG has • Strong and robust leadership; • Robust governance arrangements • Has effective systems in place to ensure compliance with its statutory functions. • The CCG secures the range of skills and capabilities it requires to deliver all of its Commissioning functions, using support functions effectively, and getting the best value for money
• **Domain 2a:** Performance – delivery of commitments and improved outcomes	Demonstrates the CCGs commitments to improved outcomes and the CCG's focus on how well the CCG delivers improved services, maintains and improves quality, and ensures better outcomes for patients

• **Domain 2b:** Quality (Improved Outcomes)	Demonstrates the CCGS commitments to delivery and improved outcomes
• **Domain 3:** Financial Management	All consideration and delivery of change will be enacted within the running cost envelope of the CCG
• **Domain 4:** Planning (Long Term and Short Term)	Demonstrates the CCGs responses to the 5YFV, the STP planning, realisation of the 5 yr. CCG strategy and the 17/18 – 18/19 Operating plan
• **Domain 5:** Delegated Functions	Demonstrates the CGG commitment to actively commission Primary Care as fully delegated organisation

1. BACKGROUND AND CURRENT SITUATION

1.1. The CCG adopted the Primary Care strategy and implementation and this was endorsed by the members and approved by the CCG GB. A major component of this is the commitment to delivering against and MCP model as part of the 5YFV challenge. This report provides an update with regarding to current new models of care configuration and supporting activities to deliver against this.

2. MAIN BODY OF REPORT

2.1. Attached as appendix 1 is the current status of Primary Care alignment to emerging Agreements/Collaborations/Federations

2.2. Also attached is the 5 year Plan on a Page (PoP) to support the formation and effective functioning of the emerging groupings of primary Care practices

3. CLINICAL VIEW

3.1. N/A

4. PATIENT AND PUBLIC VIEW

4.1. N/A at this moment, but if these changes result in alterations to how and where GP Primary Care is delivered, appropriate public and patient consultation and engagement will take place

5. RISKS AND IMPLICATIONS

Key Risks

5.1. There remains an as yet un-quantified risk to services and outcomes as a result of the adoption of new models of care. The CCG intends to mitigate this by instituting a structured development programme of capacity and capability enhancement with the new practice Groupings/Collaborations/Federations in line with the transfer of services to the new models. By learning from early adoption or concurrent activity taking place in other health economies, the CCG will minimise disruption to the effective functioning of services in the Wolverhampton health economy as a whole

Financial and Resource Implications

5.2. The delivery of the model may result in a different configuration of staff (resource) support in the structures of the CCG and/or MCPs. There is a separate development programme of work being undertaken to define this.

5.3. It is the intent of the CCG that all changes to structures and services ill be delivered within the limitations of running Cost Allowance (RCA) and programme budgets

Quality and Safety Implications

5.4. These will be defined as the programme unfolds

Equality Implications

5.5. These will be defined as the programme unfolds

Medicines Management Implications

5.6. N/A

Legal and Policy Implications

5.7. Legal implications will need to be defined as the programme of work develops

6. RECOMMENDATIONS

The Governing Body is asked to

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

Name Steven Marshall
Job Title Director of Strategy and Transformation
Date: 17 November 2016

ATTACHED:

Primary Care - New Models of Care

NHS
Wolverhampton
Clinical Commissioning Group

Aim

Wolverhampton's Primary Care Strategy is underpinned primarily by delivery through a Multi Speciality Community Provider (MCP) contracting model, delivered by care hubs supported by integrated teams.
The introduction of care hubs enable the new care model to deliver improved access, improved care co-ordination and continuity of care in the community whereby care can be provided closer to home and in the community setting as far as reasonably practical.

Scope

- Primary Care Strategy implementation focussing on practice groupings, commissioning at scale provision, estate & IT developments, and clinical & non clinical workforce to cultivate group functionality with new roles to strengthen functionality.
- Community Neighbourhood Teams, wrapped around groups of practices including community matrons, specialist nurses (including paediatrics), social workers, mental health services and the voluntary sector who will oversee patient care.
- Patients will benefit from enhanced care navigation enabling greater choice and shared decision making, advice and support
- Practices working at scale and in close collaboration with out of hours services to enable 24 hour cover in the right place at the right time
- MCPs commissioning services from providers based on population need
- Sustainability of service review based on population need demographics

Partners

- Wolverhampton Care Collaborative, Wolverhampton Total Health and Unity Wolverhampton (MCPs)
- Royal Wolverhampton Trust
- Black Country Partnership Foundation Trust
- Healthwatch Wolverhampton
- Private & independent sector providers
- City of Wolverhampton Council
- NHS England

Status

- Year 1 of 4 year implementation plan
- Primary Care Home (ministerial visit to PCH site November 2017; Wolverhampton Total Health & Wolverhampton Care Collaborative)
- 2017/18 Shadow year (Alliance Agreements)
- 2018/19 MCP Contracts awarded (Partial Integration MCP)
- 2019/20 MCP Contracts awarded (Fully Integrated MCP)
- 2020/21 Business as usual (performance & contract monitoring)

STP Footprint

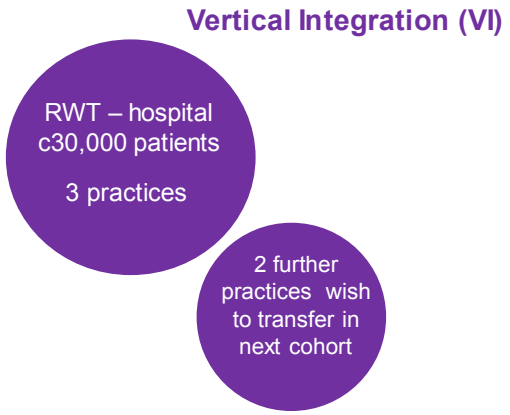
Black Country

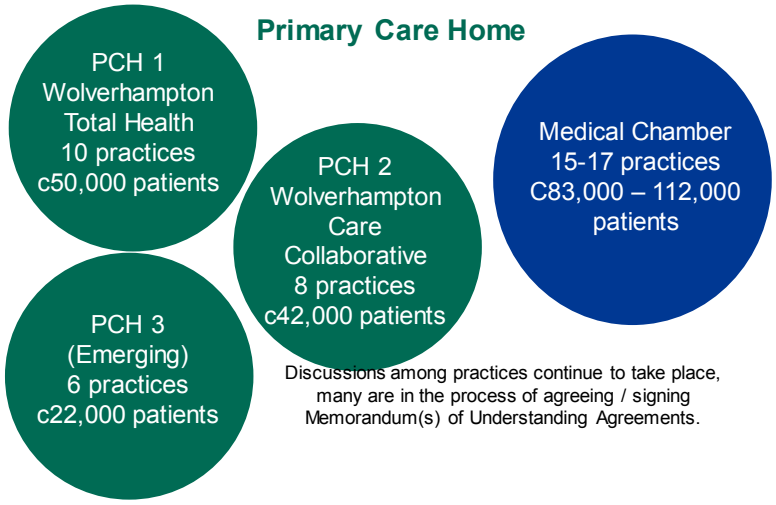
New Models of Care (Wolverhampton)

Multi-speciality Care Provider is a new deal for GP's as part of the 5 Year Forward View. This would take the shape of being a collaboration of a group practices i.e. federations, networks or single organisation(s). This is not only an opportunity to standardise back office functions and avoid replication but also a way of expanding leadership to include many healthcare professionals. Across the grouping there will be a collaborative approach to service provision whilst there will be a greater convenience for patients shifting the majority of outpatient consultations & ambulatory care out of hospital settings.

Primary & Acute Care Systems (PACs/VI) is a collaboration between NHS Trusts and GP Practices to meet the needs of registered list(s) of patients. This is an opportunities for trust's to kick-start primary care expansion but reinforce out of hospital care which could evolve into taking accountability for all health needs of a registered list of patients. Part of Vertical Integration is a greater level of back office support which will care of the business element of General Practice.

Primary Care Home is a joint NAPC and NHS confederation programme. Primary Care Home Model is based on care hubs/neighbourhood approach. Supported by the new models programme featuring provision of care to a defined, registered population between 30-50,000 people, function with an integrated workforce with a strong focus on partnerships spanning primary/secondary/social care, a combined focus on the personalisation of care with improvements in population health outcomes, alignment of clinical & financial drivers with appropriate shared risks and rewards.





Objective	2016/17	2017/18	2018/19	2019/20	2020/21
Primary Care Strategy Implementation	*Back office function review *Practice groups forming *MOUs signed & commenced new ways of working *Ten high impact actions scoped	*Launch 10 high impact action projects (IT etc) *Introduce new roles (Workforce ie Clinical Pharmacist, Mental Health Therapist, Nurse Associate, Physicians Associate & additional GPs) *Strengthen CNTs via our Better Care Programme (Specialist Nurses & Paediatrics) *Improved access (7DS) *Care Navigation; Active Patient Management; Social Prescribing all in place	*Sustain benefits from 10 high impact actions *Co-location of practices & services *Practice mergers - fewer/larger practices *Estate Strategy finalised *Estate Transformation Phase 1	*7 day primary & community services lead by practice groups via MCP contracting route *Estate Transformation Phase 2	*Business as usual for fully implemented model(s) of care including Contract Management, Risk Management, Finance & Performance & Clinical Effectiveness *Estate Transformation Phase 3
New Models of Care (MCP Framework) Primary Care Home 1&2	*Wolverhampton Care Collaborative & Wolverhampton Total Health (companies limited by share) *Priorities identified & responsive plans Launched	*Shadow Year NHS Contract practice/group *Strengthen infra-structure i.e. Business Management etc. *Development of risk adjusted capitated budgets	*MCP Partial Integration of primary & community services *Risk adjusted capitated budgets (shadow year) *Some services continue to be commissioned by CCG	*MCP Full Integration primary & community services (potential inclusion of out of hours strand of urgent care) *Full capability of acting as a lead integrator or as part of a lead integrator model and commissioning & sub-contracting service providers *Risk adjusted capitated budgets (fully integrated)	*Business as usual contracts monitored as all other providers *Provider Contract Review Meetings *Provider Clinical Quality Review Meetings
Medical Chambers	*Unity Wolverhampton (federation) *Alliance working without formalities of limited company *Priorities identified & responsive plans Launched	*Formation of limited company & associated Governance *Strengthen infra-structure ie Business Management etc.			
RWT PACs/VI	*Practices sub contract GMS to RWT *Practice staff employed by RWT	*Development of risk adjusted capitated budgets *See Checkpoint(s) below	*Risk adjusted capitated budgets (shadow year) * See Checkpoint(s) below	*Risk adjusted capitated budgets (fully integrated) *See Checkpoint(s) below	*Business as usual
Commissioned Services – Working at Scale MCPs Providing & Sub Contracting Services	*Enhanced Primary Care Schemes for delivery 2017/18 fully worked up (by Q4) *Consult on service specifications Q4 *Ten High Impact Actions launched *Peer Review of RightCare Pathways *Development of Local Quality Outcomes Framework/Incentive Scheme *Identify areas for priority investment based on population need	*Small scale service provision (EPCS) *Embed ten high impact actions (7DS , reduced DNAs etc) *Phase 1 services/pathways specified & commissioned from MCP; Frail Elderly, Diabetes, EOL, *Phase 2 services/pathways Community services planned *'RightCare' Pathways including LTC Management being addressed by MCPs *Commence transfer or services to community setting i.e. diagnostics (community ECG Reporting & Echo Clinics)	*MCPs & CCG both commissioning different aspects of community services *Including those carried forward from 2017/18 & new services defined in Commissioning Intentions *Roll out of Phase 2 Community Services commissioned from MCPs *Plan service requirements in preparation for full Community Service MCP delivery	*MCPs commissioning/ sub-contracting services i.e. EOL/Community Services, Out of Hours *Full MCP Community services procurement	*Business as usual of at scale delivery of MCP commissioned primary & community Services
Development Support Primary Care Home 1&2	*Project Manager & Gap Analysis (Q2) aligned with PCS Committee *Branding & patient engagement (Q4) *Scope extent of variation among practices & begin standardised approach (Q4)	*CCG based commissioning Support roles including contracting, redesign/ transformation, BI & finance aligned to each group to address business management requirements (secondment/ new posts) *Develop clinical leadership *Continue to reduce variation & improve care quality *Ownership & management of demand ie referrals management & reduce variation	*Continued ownership & management of Demand on services (all sectors) *Benefits realisation of primary care clinical leadership *Commissioning and provision roles confirmed & staff employed/seconded to MCP(s) *Functional business infra-structure Implemented	*Continued development of organisational form & functions	*Business as usual
Medical Chambers	*Project Manager & Gap Analysis (Q3) aligned with PCS Committee *Branding & patient engagement (Q4) *Scope extent of variation among practices & begin standardised approach (Q4)				
RWT PACs/VI	*Project support (Q1→) *First Wave June 2016 (x3 practices) *Second Wave Feb 2017 (2x practices) *Development of trust integration team	* See Checkpoint(s) below	* See Checkpoint(s) below	* See Checkpoint(s) below	*Business as usual
Measuring Success – Dashboard(s)	*Dashboard development & launch * Care Navigation; Active Patient Management; Social Prescribing *Demand Management *Risk stratification & co-ordinated care	*Quarterly monitoring of clinical outcomes *Clinical effectiveness/use of resources *Patient choice & shared decision making *Pro-active approach to population care needs	*Introduce contract & clinical quality review processes to monitor finance, performance & clinical outcomes & reduce variation *Clinical effectiveness/use of resources	*Continuous improvement in all aspects of successful models of care *Strive for consistent	*Business as usual contracts monitored as all other providers *Provider Contract Review Meetings *Provider Clinical Quality Review Meetings

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
	*Patient & public engagement ie patient stories	*Co-production of service design through engagement with local community, clinical leaders & stakeholders	*Strive for continuous improvement based on findings/learning from monitoring & review arrangements		
Check Points	Q4 2016/17 Equality & Quality Impact Assessments for each group/model Q4 2016/17 Review of Governing Body membership & locality structure	Sept 2017 Review of CCG Infra-structure Sept 2017 Strategic Review of Care Models	Q1 2018/19 Review of Commissioning Intentions Q1 2018/19 Serve Notice on Contracts Q2 2018/19 Strategic Review of Care Models	Q1 2019/20 Strategic Review of Estate Q1 2019/20 Strategic Review of Care Models	Business as usual commissioned provider governance arrangements

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body Meeting – 13th December 2016

Agenda item 13

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

2. MAIN BODY OF REPORT

2.1 Care Pathway Clinical Decision Support System

Members of the Committee were informed that there is a budget pressure in GPSOC which needs to be addressed. The CCG pays for the DXS clinical decision support system in all 45 GP practices in Wolverhampton, however, the system is used by only 8 practices.

The Committee supported the following recommendations;

- The needs of the GP practices to be understood
- Procure and build an appropriate solution
- Deliver this within the financial envelope
- An interim solution to be adopted to ease budget pressure is to only procure DXS for those actively using the system, however, there needs to be a short timeline for resolution as there is inequity in access/usage.

2.2 Decommissioning of Glucosamine

The Committee received an update on the success of the decommissioning of Glucosamine based on NICE guidance.

All patients have now had their glucosamine stopped with the exception of 1. On review it was noted that this patient had been prescribed the drug on the advice of a consultant for a condition outside of those within the guidance and hence will continue to have it prescribed.

Patients who were taking the drug were offered a referral to healthy lifestyle services via Public Health as part of the exit strategy. No formal complaints were received by the CCG following the disinvestment decision.

Efficiencies of approximately £150k have been made following the disinvestment and the process is deemed to have been a success.

Prescribing of this drug will be monitored periodically and reminders given where required that NICE guidance does not support this.

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

2.3 Contracting & Procurement Update

Members of the Committee were provided with an overview and update of key contractual issues, predominantly relating to Month 6 (September) activity and finance performance.

An update was received on the position of the current contract negotiations for 2017/18 and 2018/19.

It was noted that the stand still period for the award of the MSK procurement has ended and discussions have commenced with the successful provider; Care UK.

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

2.4 Contracts for TB and Infection Prevention

The Committee was asked to endorse the proposal for the LA and CCG to work collaborative to align the contracts for TB and Infection prevention. The aim is to identify cost efficiencies and to improve the patient pathway.

The Committee endorsed the proposal which will be taken to the next Commissioning Executive Board meeting.

Action – The Committee request that Governing Body support the action taken.

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 November 2016**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body - Tuesday 13th December 2016

Agenda item 14

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

Key issues of concern for noting

Legend

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

Key Issue	Level	Comments	Detail on page/RAG
SBAR issues escalated	2	• Delayed diagnoses • Delayed treatment • Sub-optimal care (transfer of patient) • NE Quality Visit 14/11/16	4/5
Pressure Injury Grade 3	1	Close monitoring	6/7
Health Acquired Infections- CDiff	2	Potential risk of increased incidence and potential harm RWT has reached its annual target	7/8
Performance Improvement notices impacting on Quality	2	Meetings with RWT held regularly and action plans agreed. More detail will be covered by the Finance and Performance paper.	
Workforce- RWT Risk Register	2	RWT Nursing and consultant recruitment issues are impacting on Quality and Patient Safety and A&E performance.	10/11
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 undertaken on 31st October 2016.	16
LAC	2	Wolverhampton remains an outlier for number of LAC. There is a city wide strategy in place with improvements seen.	13/14
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.	11/13
CQC Inspection Reports (BCPFT & RWT)	2	Rating 'requires improvement' for RWT & BCPFT Action Plans in place.	8/9
CQC General Practice	1	2 practices are being supported for 'requires improvement'	9

1.0 BACKGROUND AND CURRENT SITUATION

The CCG's Quality and Safety Committee meets on a monthly basis. This report is a material summation of the Committee's meeting on 8th November 2016 and any other issues of concern requiring reporting to the Governing Body since that time. In addition, the presenter of this report will provide a verbal update on any key issues that have come to light since this report was written and about which the Committee decided needed be escalated to the Governing Body.

2.0 PURPOSE OF THE REPORT

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

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

3.0 CURRENT SITUATION

3.1 Weekly Exception Reports

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

3.1.1 An incident has been reported by RWT that whilst undertaking an emergency reduction of a dislocated hip a complication which was evident on the x-rays but had not been noticed prior to the surgery was discovered. The procedure was abandoned and the child was transferred to BCH for specialist assessment and repair.

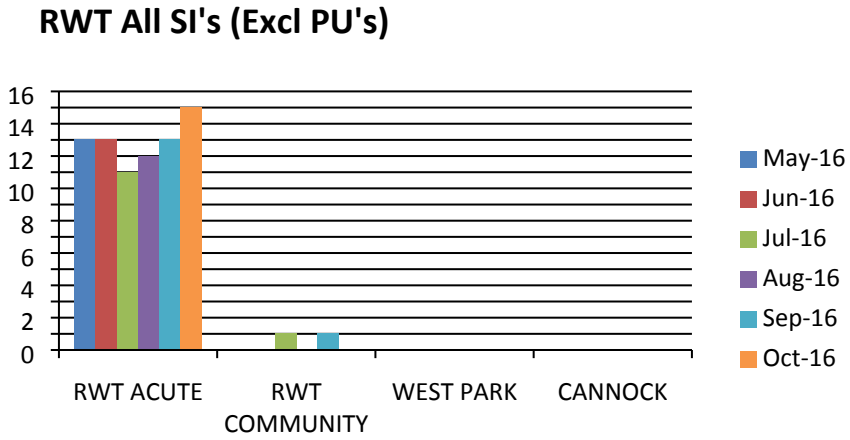
3.1.2 An unexpected death of a child has been reported by RWT. The child was brought into A&E lifeless and was certified as deceased on arrival. The injuries are suspected to be non-accidental, police and social services are involved and full investigations have been initiated. Guidance in line with Sudden Unexpected Death implemented. This case has attracted some media attention in the week and it was reported that the parents have been charged with murder.

3.1.3 An incident has been reported by The Nuffield Hospital regarding the professional conduct of locum consultant. This is being investigated by the police and local hospitals where intelligence suggested that this consultant was providing services for have been notified and appropriate actions taken.

4.0 THE ROYAL WOLVERHAMPTON NHS TRUST

4.1 Serious Incidents (SIs)

16 new Serious Incidents were reported by RWT in October 2016.



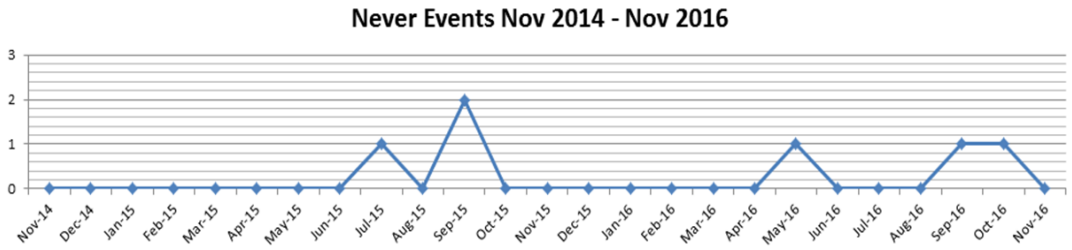
The Trust has completed an external review of SIs reported from key areas as A&E and emergency admissions areas. The report is being written and the findings will be shared at the January 2017 CQR meeting. The National Reporting and Learning System monitors all NHS Trusts for reporting timescales and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

4.3 Never Events

RWT reported its 3rd NE for the current year in October 2016. (See chart page 6).
The most recent NE is related to an injection of Lucentis medication into the wrong eye. A full investigation is underway; early causes suggest a failure in adherence to Trust Policy that a patient without a signed consent should not leave the ward for theatre until this has been corrected.

A planned review visit made up of reviewers from the Quality and Safety Team at the CCG and expert nurses from neighbouring provider ophthalmic units was undertaken on 14th November 2016. The final report is being concluded and detail will be shared with the Governing Body at a further meeting.

As an immediate action the department took action to ensure that notes are checked on the day before the clinic for signed consent forms, missing consent forms actioned and no patients will leave the ward without a valid and appropriate consent form in the notes. The eye is also marked for completeness.



Date	Category	Total
July 2015	Wrong site surgery	1
Sept 2015*	Wrong side procedure	1
Sept 2015*	Wrong side procedure	1
Total 2015/16		**3**
May 2016	Maternity/obstetrics	1
Sept 2016	Wrong side procedure	1
Oct 2016*	Wrong side procedure	1
16/17 ytd		3

***wrong side eye injection**

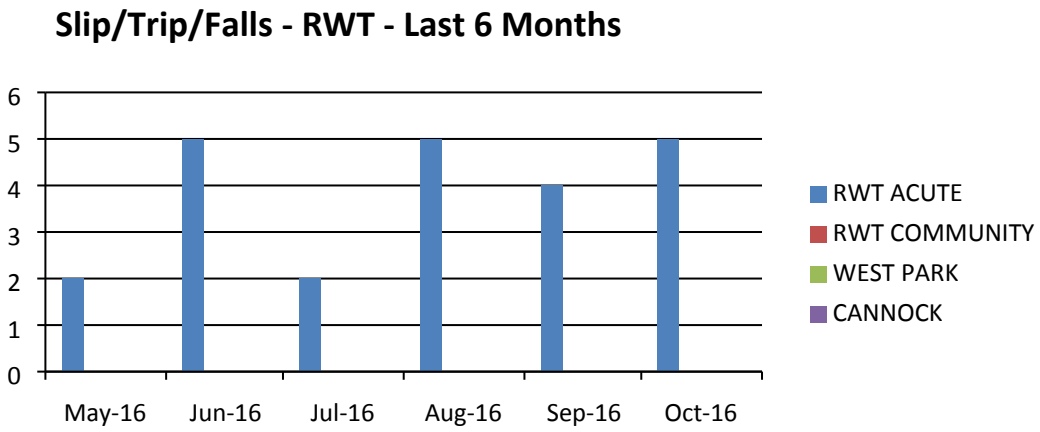
4.4 Slips Trips and Falls (causing serious harm)

Five slip/trip/falls were reported by RWT in October 2016. One of the wards has been placed under 'special measures' by the Trust and further deeper dives and all intelligence on this ward are being triangulated. The Trust is reviewing leadership, staffing, infection and prevention audits, education and training on this ward. Dashboards are presented at the CQRM meetings with actions taken to address shortfalls.

There have been zero reported falls at West Park, community or Cannock Chase Hospital.
The RWT Falls Group continues to meet on a monthly basis. The RWT Falls Policy has been reviewed (Prevention and Management of Falls). This is as a result of feedback from the National Inpatient Falls Audit. It was ratified by the Trust Board in October 2016.

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

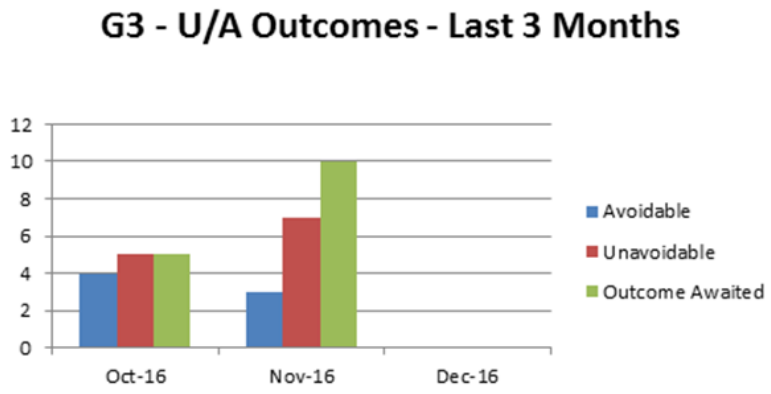
- Standardisation of policy and process
- Standardisation of assessment technique and paperwork
- Renewed enhanced care training for patients being nursed on 1:1



4.5 Pressure Injury Grade 3

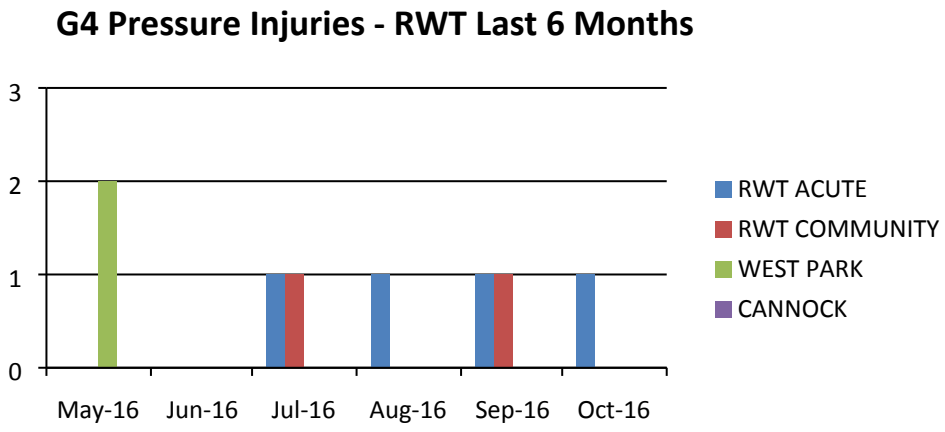
The work of the Health Economy Pressure Injury Prevention Steering Group continues to uncover the variations in care, understanding, education and training across the health economy.

The improving trend continues into October; 14 Grade 3 Pressure Injury incidents were reported by RWT; 8 at RWT site and 5 in the Community. Of those incidents, some have been closed and the chart below shows avoidable or unavoidable. There are still 5 incidents from October that are awaiting final sign off.



4.6 Pressure Injury Grade 4

The single Grade 4 Pressure Injury incident reported by RWT in October was deemed as avoidable.



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

The Trust has reached its total target for the year (35), however, has shown some improvement in the monthly numbers for the last 2 months.

The quarterly rate/100,000 bed days has reduced to below the national average for the last two months and the quarterly rate/100,000 population has reduced to below the regional average for the last 2 months.

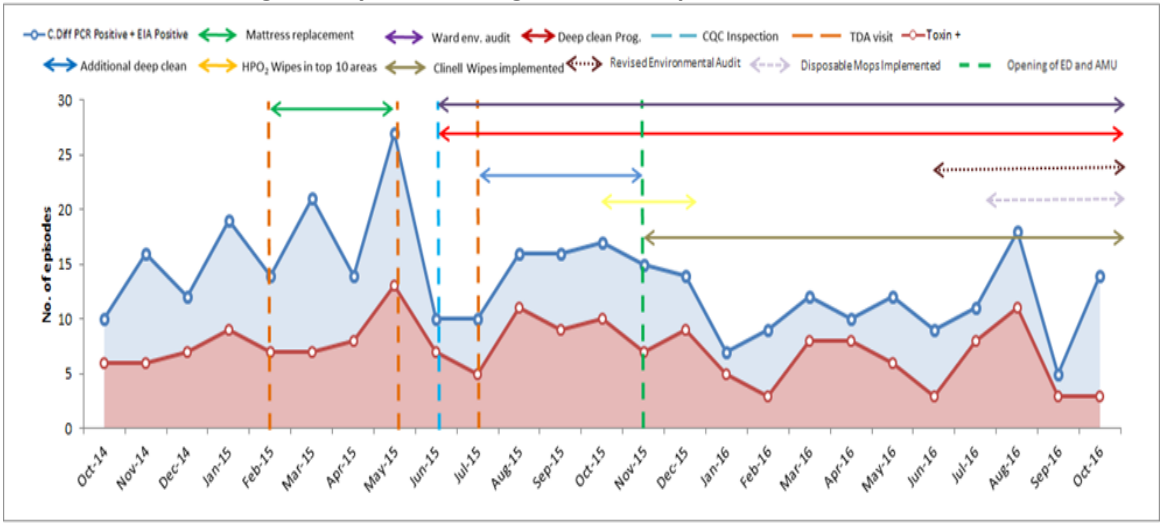
There are no associations found in relation to the typing results which suggest there is no evidence of cross contamination due to hand hygiene, equipment or environmental factors.

The following activities remain a focus:

- Decant and deep cleans are on schedule
- Antibiotic prescribing audits
- Monthly and quarterly ward audits for hand hygiene, environment and equipment
- Disposable mops/curtains implemented
- Time to treatment plateaued, action plan in place.
- Time to isolation showing some improvement.
- Out of hours on call management systems in place
- Management of community outbreaks robust (no community outbreaks reported and CCG is below its annual target).
- Local health economy wide antimicrobial resistance project has commenced (CCG is supporting this with funding to buy the CRP testing kits for primary care and urgent care centre).

Discussions are held at CQRM/Contract Review Meetings and sanctions in line with contract management will be applied.

Chart showing activity for reducing Cdiff action plan 2014-2016



4.7.1 MRSA Bacteraemia

Zero reported.

4.8 West Midlands Quality Review Service

The draft report for the review of imaging services which took place on September 21st 2016 at RWT has been received by the Trust and CCG. Immediate risks were notified to the Trust at the time of the review and a letter of assurance has been received by WMQRS and CCG from the Chief Executive

that these issues have been addressed. The Trust has formally responded and we are awaiting the final report with action plan. This will be monitored at CQRM/CRM.

4.9 Performance

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

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

4.10 Regulator concerns

4.10.1 CQC RWT

The Trust has received its final report for the inspection in 2015. The rating remains unchanged 'requires improvement' and this is now available on the CQC website. The action plan has been monitored at CQRM and is now closed.

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 unfortunately still not received. As previously reported, a Strategic Stakeholder Group has been set up and meetings have been progressed. The function of this group is to seek demonstrable assurance that the actions are being progressed and how they are being embedded. Assurance is reported to the Local Children's Safeguarding Board.

4.10.2 OFSTED Inspection

The CCG has been informed that an OFSTED inspection will now not occur until the New Year. The preparatory teams continue to meet to ensure that the framework assessments for any sector; including health meet all the statutory requirements effectively.

4.10.3 CQC General Practice

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

4.12.3 CQC BCPFT

BCPFT CQC Risk Summit was held in May 2016. A substantial action plan is in place and this is being monitored at CQRM and Contract Meetings. A further visit from CQC took place on 17th October 2106 and the final report is awaited.

4.12.4 Health and Safety Executive

RWT received a Notice of Contravention for Radiology Department, the Trust has responded and we are awaiting the final reported recommendations and Trust action plan.

4.12.5 Healthwatch

Following discussions with RWT and Healthwatch, it has been agreed that where possible scheduled quality visits to the Trust will be joint with Healthwatch and CCG. Healthwatch colleagues have accompanied the CCG Quality and Risk Team on 3 visits to date. More dates are being planned for the New Year.

4.13 Mortality (RWT)

The published SHMI, released by the Health and Social Care Information Centre (HSCIC) for July 2015 to July 2016 is 1.06 which has increased compared to previous periods and banded "as expected".

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%.

Mortality Audits have been undertaken for patients with a primary diagnosis of Pneumonia (Oct 2015- January 2016) and Fluid and Electrolyte Disorder (May 2015 to March 2016).

1. **Pneumonia**. 80 cases, representing 56% of the total deceased cases were reviewed and generally care was found to be of a very good quality. Areas of good practice were highlighted and also recommendations made for improvements and learning. The RWT Mortality Review Group oversees the dissemination of the information from this audit via the matrons in the clinical areas and any action plans arising from the findings.
2. **Fluid and Electrolyte Disorder**. Thirty five cases, representing 60% of the total deceased between May 2015 and March 2016) were randomly selected from the cohort of adult patients admitted with a diagnosis from the Fluid and Electrolyte disorder group, who subsequently died either in the hospital or within 30 days post discharge. The cases that were identified as being incorrectly coded were subsequently recoded and excluded from the sample. No findings of sub optimal care or avoidable mortality identified, however, more work is being undertaken to understand causes of variation in coding across acute trusts in England.

The CCG has been working with NSHE and RWT on how learning from avoidable deaths in primary care can be included in the Trust mortality review meetings. This has progressed, a clinical lead from one of the VI practices has been approached to invite to the group, once membership is established this will be progressed. Membership will be confirmed at the next RWT MRG meeting.

4.15 Workforce

The Chief Nurses provide a monthly report with information on inpatient nursing and midwifery staffing. This data is also made available on the Trust intranet site and NHS Choices. Improvements and challenges have been noted in the following areas:

- Registered Nurse fill day duty fill rate has improved since January 2016 from 11 wards that did not meet the minimum requirements to 3 in October. This is reflective of the band 5 recruitment that the Trust has undertaken this year of local, European and Filipino nurses (c100 band 5s in the last few months). A further 123 nurses are in the pipeline at various stages of the immigration process.

- RN fill rate for night duty remains a challenge as most new recruits cannot be assigned without supervision and cannot undertake the enhanced duties as administration of IV medications.
- HCA fill rates for day and night duty have improved slightly.
- Retention of staff- RWT is a pilot site to deliver the Associate Nurse Foundation Degree Programme for 20 HCAs who will commence training in Jan 2017.
- Band 7 leadership modules are being pursued to improve leadership and support skills for band 7 nurses.
- There are currently 225.37 (wte) registered nursing vacancies open across the Trust, a small reduction from September which was 239.10. Allowing adjustment for those that have been offered but are awaiting start dates there is a nursing workforce gap of 134.69 WTE as at the end of October 2016.
- Nurse turnover for bands 5-7 is decreasing slightly i.e. band 5 turnover is now at 10.97% compared to 13% in April.
- Medical workforce recruitment is on-going with 3 consultants for A&E successfully interviewed in November. All 3 have accepted and are due to commence with the Trust early in the New Year.

The CCG Assurance Framework allows the Quality Team to review themes from the ward dashboards to triangulate low staffing with other patient safety incidents and intelligence.

5.0 BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST
Level of Concern as of 31st October 2016

Black Country Partnership	
Month	**Concern Level and Actions**
Oct 2016	Level 2 –2015 CQC rating was requires improvement. SIGINFICANT progress has been made. This rating is likely to improve when outcome of recent review has been confirmed.

a) PREVENT Training

Remedial action plan agreed in June. This will be monitored via CQRM and Contract Review Meetings. In October, a contract performance notice was agreed. This is being monitored monthly.

b) Early Intervention Service

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

5.1 Serious Incidents

In October 2 SIs were reported. Full investigations are in place therefore a final category has not yet been agreed.

5.2 **Never Events** – zero reported

5.3 **Falls** – zero falls were reported.

5.4 **Numbers of Overdue SI's** – zero

5.5 **Overdue National Patient Safety Alerts (NPSA)** – nil that we are aware of at the time of writing this report.

5.6 **NHS Safety Thermometer**

BCPFT's harm free care rate for October 2016 was 97.48% this is an improving picture from previous performance.

5.7 Items to Note from October Mental Health Themed Clinical Quality Review Meeting:

- Adults of Working Age - there was a reduction in incidents in August. Violence & aggression accounts for the highest rate of incidents but they are low level, and the highest rate was seen on Macarthur ward.
- The Trust is looking at renewing admission criteria to address the higher levels of acuity among patients. There have been issues in PICU with some patients requiring medium to high secure facilities, however staff are struggling to find appropriate placements for them. The financial implication of this has been raised with NHSE and there is also a high impact on staff and patient safety. Risk management is being reviewed with staff.
- The Trust is encouraging the raising of concerns before they escalate into complaints and has developed a weekly tracker to manage complaints.
- A patient story included within the division's monthly report was from a patient on Macarthur ward who was responsible for 40+ incidents of violence & aggression who, upon discharge, wrote to all staff acknowledging and apologising for his challenging behaviour. It was noted that this was a result of the good work staff had done with the patient.
- There are high rates of sickness absence and policies are in place to manage this. Sickness in planned care is largely due to long term physical health issues.
- Following an issue whereby a patient blocked a door with a chair, the Trust has identified risks with doors in rooms and confirmed that an override mechanism can be used in emergencies. Doors are checked on rotation to ensure mechanisms are working.
- Additional work is being done to establish the threshold for the length of prone restraints. Trust staff has been recognised for their work on restraint and have contributed to a national report. Risk assessments are included in care plans in place across the Trust. It was noted that staff are not trained to put patients into a prone position, however patients may put themselves in this position and it is in the interest of their safety to hold them there until de-escalation is possible. A report into restraint will be presented to CQRM in December.
- Workforce - The sickness absence rate is at 6.1% and is being managed locally. Proactive Health and Wellbeing Boards are working on this.

The vacancy rate is at 15.1% and work is on-going. The rise includes new posts which are being actively recruited to.

The staff turnover rate is at 15%, predominantly in corporate services.

Bank/agency usage is closely monitored via the national framework. The Trust has reduced its use of agency over recent months following roster management workshops and close work with the finance team.

6.0 OTHER SECTORS

6.1 Nuffied Hospital – CQRM held, no issues of concern were noted.

6.2 Vocare – The Vocare CQRM in October was the first combined quality and contract review meeting. Discussions set out the required standard of quality reporting that is required. CCG Quality Team will continue to support to improve this going forward.

7.0 CHILDREN'S SAFEGUARDING

7.1 Serious Case Reviews

There are two serious case reviews currently underway. Publication dates are not known and the Governing Body will be kept appraised.

7.2.1 OFSTED Inspection

The 2016/17 OFSTED Inspection schedules require that Wolverhampton OFSTED inspection will be completed before May 2017. A multi-disciplinary OFSTED team from all the key stakeholders have been deployed in Wolverhampton for several months now in preparing for the inspection. The next opportunity for the inspection will now be after January 2017. All stakeholders have undertaken a very comprehensive predatory assessment and once a formal notification is received the mobilisation team will lead on informing and leading on the inspection.

7.3 Looked After Children

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

	Number	%age
Wolverhampton City Council	**271**	**43.2**
Dudley Metropolitan Borough Council	40	6.4
Sandwell Metropolitan Borough Council	29	4.6
Walsall Metropolitan Borough Council	60	9.6
South Staffordshire Council	35	5.6
All in Adjoining LAs	**164**	**26.2**
Anywhere Else - not in Wolverhampton or in Adjoining LAs	**192**	**30.6**
TOTAL LAC*	**627**	**100**

- as of October 30th 2016

THE Governing Body are informed that there will be some significant staffing changes to the LAC Professionals team in the New year and plans are in place to ensure continuation of a safe and effective service.

- The Designated Senior Nurse for LAC post which has been 18 month fixed term post has been reviewed and as of immediate effect has been approved for permanent status. This is a statutory post for the CCG and the review has confirmed that in order to fulfil strategic elements of the post, it is required as a full time permanent post. HR advice has been sought.
- The Designated Doctor for LAC is taking leave for one year, beginning 1st January 2017. Exec Nurse has met with the Medical Director at RWT to agree a successor. Dr Simons will undertake this role and has many years' experience in LAC work.
- There are also discussions of further change in staff in April 2016; this is being managed via RWT MD and CCG DON and succession planning with the leaving incumbent.
- The current GP Lead for Safeguarding Children is on sick leave, this work is being managed by the safeguarding teams and arrangements have been made to service any requirement for undertaking CCG responsibility for Serious Case Reviews.

It is imperative that the availability of expert advice and support to the CCG from safeguarding professionals is not weakened at any time and even more so when an OFSTED inspection is imminent. The Governing Body can be assured that all steps have been taken to sustain and maintain a safe position in mitigating this high risk.

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.

8.2 Multi Agency Safeguarding Hub (MASH) Arrangement

Both the Children's and Adults MASH have now been in place since January and August respectively. The MASH arrangements are working well and key stakeholders are evaluating impact and effectiveness on a continuous basis so that issues which come to light can be addressed immediately. In general, the quality of the referrals being made into the MASHs' are of a good quality are appropriate.

9.0 CARE HOMES

The CCG's Quality Nurse Team continue to work closely with the Adult Safeguarding Team at the Local Authority and to oversee investigations and support the Local Authority with quality concerns. Four nursing homes remain suspended under partial or full suspension within the city. One of the homes is being managed under the Local Authority's Failing Home Policy.

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

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. Nine contracts were awarded in the first wave and a significant more are expected in the second wave. Dashboards have been developed to monitor the said care homes which are allowing, for the first time, the CCG to undertake analysis on good quality metric data. Homes of on-going concern are supported for education, training and leadership training.
Out of area homes which have Wolverhampton health or social care funded patients and that are of concern are monitored jointly with CQC and City of Wolverhampton Council. NHSE have a wider remit to share this information at Quality Surveillance Group Meetings.

10.0 ADDITIONAL ASSURANCE INFORMATION TO NOTE

10.1 Supporting Walsall Maternity Services

Wolverhampton and Walsall Clinical Commissioning Groups, Royal Wolverhampton Hospitals NHS Trust have agreed to increase its delivery capacity by 500 deliveries in 2016/17 to ensure the sustainability of maternity services at Walsall Manor Hospital.

Increased activity commenced on 21 March, mothers from 6 practices identified on the Wolverhampton and Walsall border have been booked for their maternity care to be met at Royal

Wolverhampton Trust. Both CCGs are working closely with the trust to ensure patient safety standards are maintained. A joint quality review visit is planned for 31st October 2016. A verbal update will be given at the Governing Body meeting on 8th November.

Assurances have been acquired regarding:

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

Antenatal and Post natal care will continue to be provided by Walsall Community Midwives in most cases.
Chronology of actions to date includes:

June: Walsall maternity capping monitoring meetings now completed.
July: Commence Black Country data collection exercise for maternity services and commissioning semi structured interviews re: maternity services. This has been completed.
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, Staffordshire, Wolverhampton Commissioners, Public Health and Healthwatch quality visit to RWT Maternity Unit was undertaken on 31st October 2016. The review was very positive, no key areas of concern were noted and a full report has been shared for factual accuracy with the Trust. On-going progress will be monitored at CQRM and the joint commissioner meetings. Governing Body will be kept appraised of any significant or exceptional risk.

10.2 Quality Visit to the Eye Hospital RWT

Following on from the recent NE in ophthalmology, a quality visit was undertaken on 14th November 2016. The review team was made up from the CCG Quality Team and 2 expert matrons from neighbouring provider ophthalmic units. A couple of significant issues were raised with the Trust for immediate attention to ensure patient safety and a full report is being compiled to share with the Trust in the next week. The action plan will be monitored via CQRMs.

10.3 Internal Audit Risk Management (PwC)

This has now been completed and a draft report has been shared with the CCG Audit and Governance Committee. The Exec Team are reviewing the action plan; some work has already commenced in relation to the proposed new BAF layout and on-going risk management processes. This will be shared at the next Governing Body Development Session in December and a further assurance report regarding progress will be provided to the Governing Body in February 2017.

10.4 Improving Quality in Primary Care – Full Delegation expected April 2017

Discussions have commenced with NHSE as to the legacy and handover of current NHSE responsibilities to the CCG Quality Team for the expected full delegation in April 2017. Once known, the impact of these will be assessed on the current capacity and capability of the team.

10.5 Equality Delivery System (EDS2)

The CCG is required to publish its Equality Delivery System (EDS2) on its website by 31st March 2017. Plans are in place to ensure that the CCG meets this requirement and further progress updates will be made at January and February Governing Body meetings with a final sign off in March.

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 November, information from Quality Review Meetings held during the month of October 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.

Any items identified for escalation have been reported at the front of this report.

13.0 Patient and Public View

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

14.0 Risks and Implications

14.1 Key Risks

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

14.2 Quality and Safety Implications

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

14.3 Equality Implications

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

14.4 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 reviewed and updated.

15.0 Recommendations

For **Assurance**

- **Note** the actions being taken.
- **Note** the actions in relation to the CQC Safeguarding and LAC Review in July 2016 and the preparedness for the pending OFSTED Inspection.
- **Note** the steps being taken regarding the NE in Ophthalmology at RWT
- **Note** the steps being taken regarding BCPFT safeguarding/PREVENT training compliance
- **Note** the progress with the EDS2 work for meeting statutory requirements by March 2017.
- **Continue** to receive monthly assurance reports

Name: **Manjeet Garcha**
Job Title: **Director of Nursing and Quality**
Date: **1st December 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**	**1.12.2016**
Public/ Patient View	**NA**	
Finance Implications discussed with Finance Team	**NA**	
Quality Implications discussed with Quality and Risk Team	**Report of Q&RT**	**1.12.2016**
Medicines Management Implications discussed with Medicines Management team	**David Birch**	
Equality Implications discussed with CSU Equality and Inclusion Service	**Juliet Herbert**	**1.12.2016**
Information Governance implications discussed with IG Support Officer	**Michelle Wiles**	
Legal/Policy implications discussed with Corporate Operations Manager	**NA**	
Signed off by Report Owner (Must be completed)	**Manjeet Garcha**	**1.12.2016**

(V1.0 final)

WOLVERHAMPTON CCG

GOVERNING BODY
13th December 2016

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 29th November 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	£351.100m	£351.100m	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	308	37	(271)	G
Maximum closing cash balance %	1.25%	0.15%	-1.10%	G
BPPC NHS by No. Invoices (cum)	95%	99%	-4%	G
BPPC non NHS by No. Invoices (cum)	95%	93%	2%	A
QIPP	£6.00m	£5.32m	£0.68m	A
Programme Cost £'000*	194,217	195,036	819	G
Reserves £'000*	1,038	0	(1,038)	G
Running Cost £'000*	3,240	3,160	(80)	G

- The net effect of the three identified lines (*) is a small underspend and the green rating refers to the overall position.
- QIPP is slightly below target for Month 7 albeit anticipating full delivery including the unallocated QIPP by year end.
- Cash balances have returned to levels within NHSE guidelines.

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

	Annual Plan £'000	YTD Performance M07			
		Plan £'000	Actual £'000	Variance £'000 o(u)	Var % o(u)
Acute Services	181,259	105,734	106,598	864	0.82%
Mental Health Services	34,624	20,197	20,192	(6)	(0.03%)
Community Services	37,645	21,976	21,700	(276)	(1.26%)
Continuing Care/FNC	12,259	7,151	7,793	642	8.98%
Prescribing & Quality	52,180	30,638	29,380	(1,258)	(4.11%)
Other Programme	16,252	8,521	9,373	852	10.00%
Total Programme	**334,219**	**194,217**	**195,036**	**819**	**0.42%**
Running Costs	5,555	3,240	3,160	(80)	(2.46%)
Reserves	5,154	1,038	0	(1,038)	(100.00%)
Total Mandate	**344,928**	**198,496**	**198,196**	**(299)**	(0.15%)
Target Surplus	6,172	3,530	0	(3,530)	(100.00%)
Total	**351,100**	**202,026**	**198,196**	**(3,829)**	(1.90%)

The table below details the forecast out turn by service line at Month 7.

	Annual Plan £'000	Forecast Outturn at M07			Forecast Outturn at M06			In Month Movement
		Actual £'000	Variance £'000	Var %	Actual £'000	Variance £'000	Var %	£'000 o(u)
Acute Services	181,259	183,741	2,482	1.37%	183,436	2,177	1.20%	305
Mental Health Services	34,624	34,805	182	0.52%	34,220	(87)	(0.25%)	269
Community Services	37,645	36,291	(1,354)	(3.60%)	36,291	(1,354)	(3.60%)	0
Continuing Care/FNC	12,259	13,321	1,062	8.67%	13,286	1,027	8.38%	35
Prescribing & Quality	52,180	50,681	(1,499)	(2.87%)	50,182	(1,459)	(2.82%)	(40)
Other programme	16,252	17,158	906	5.58%	18,226	1,474	8.80%	(568)
Total Programme	**334,219**	**335,998**	**1,780**	**0.53%**	**335,641**	**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	**351,100**	**351,100**	**(0)**	(0.00%)	**350,743**	**0**	**0.00%**	**(0)**

- The Acute portfolio variance is due to adverse movements in RWT, smaller acute providers and the Non Contract Activity portfolio which due to its nature is subject to fluctuations.

- The above table reflects the new FNC rates which have created a cost pressure.

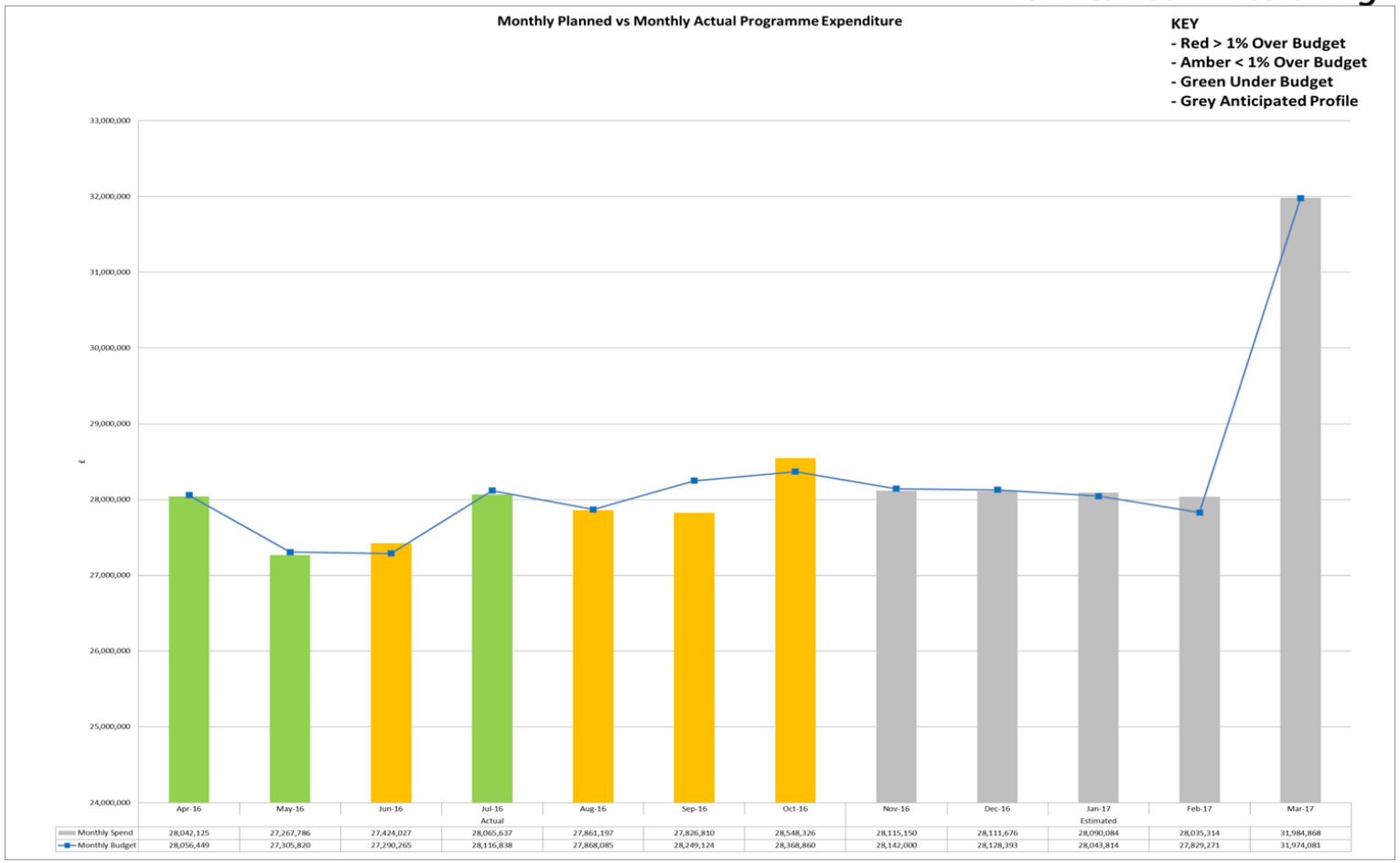
- Community Services under spend is due to the marginal threshold being invoked and assumptions regarding costs recovered for a ward closure in West Park and recruitment slippage in the Rapid Response Nursing Team.

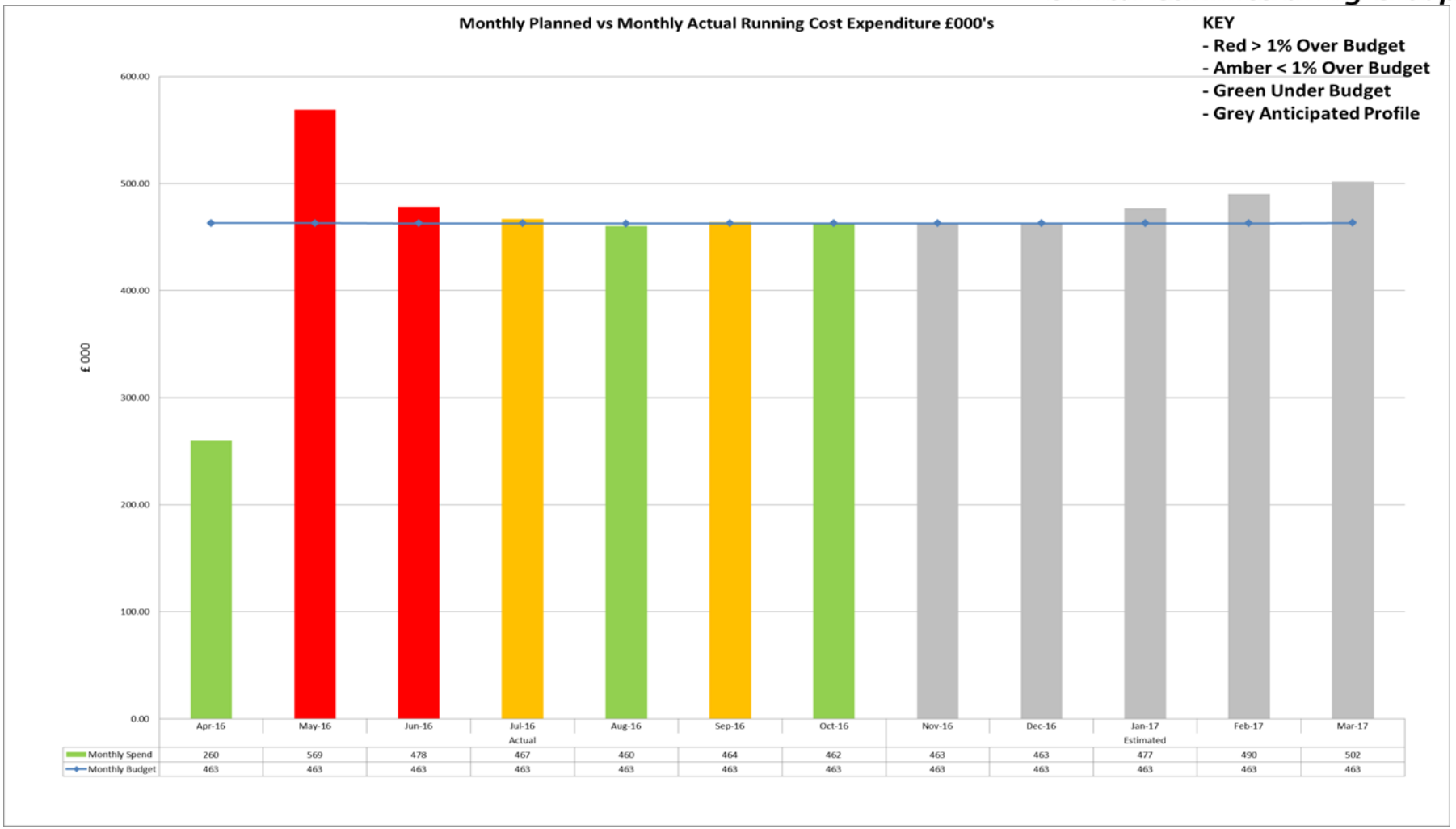
- Prescribing is continuing to underspend and Month 7 reflects a small increase in under spend.

- The adverse variance in Mental Health relates to more individual cases requiring higher cost packages and high level observations.

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

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


Monthly Planned vs Monthly Actual Programme Expenditure
KEY
- Red > 1% Over Budget
- Amber < 1% Over Budget
- Green Under Budget
- Grey Anticipated Profile
33,000,000
32,000,000
31,000,000
30,000,000
29,000,000
28,000,000
27,000,000
26,000,000
25,000,000
24,000,000
£
Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17
Actual
Estimated
Monthly Spend 28,042,125 27,267,786 27,424,027 28,065,637 27,861,197 27,826,810 28,548,326 28,115,150 28,111,676 28,090,084 28,035,314 31,984,868
Monthly Budget 28,056,449 27,305,820 27,290,265 28,116,838 27,868,085 28,249,124 28,368,860 28,142,000 28,128,393 28,043,814 27,829,271 31,974,081


Monthly Planned vs Monthly Actual Running Cost Expenditure £000's
KEY
- Red > 1% Over Budget
- Amber < 1% Over Budget
- Green Under Budget
- Grey Anticipated Profile
£ 000's
600.00
500.00
400.00
300.00
200.00
100.00
0.00
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Actual
Estimated
Monthly Spend 260 569 478 467 460 464 462 463 463 477 490 502
Monthly Budget 463 463 463 463 463 463 463 463 463 463 463 463

2. QIPP

The Committee noted an improvement in the QIPP Programme performance as at Month 7. The improvement in the forecast outturn is due to the identification of further QIPP within Prescribing.

	YTD Plan £'m	YTD Actual £'m	YTD Var o(u) £m	An. Plan £'m	FOT £'m	Var o(u) £m
Transactional	1.33	1.77	0.44	2.21	3.98	1.77
Transformational	3.73	3.55	-0.18	6.93	6.56	-0.37
Unallocated	0.94	0.00	-0.94	2.12	0.00	-2.12
Total	**6.00**	**5.32**	**-0.68**	**11.26**	**10.54**	**-0.72**

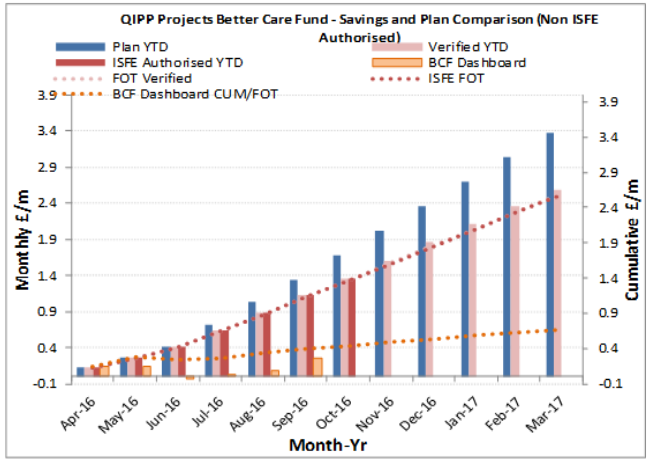
- Schemes have been identified for £10.54m (93.6%) and all but £107k is recurrent.
- QIPP Programme Board has identified the urgent need to replenish the Hopper and to move schemes that are currently in scoping or baselining to the implementation and delivery phases.
- Risk has been identified for 60% of the unallocated QIPP within the risk schedule.

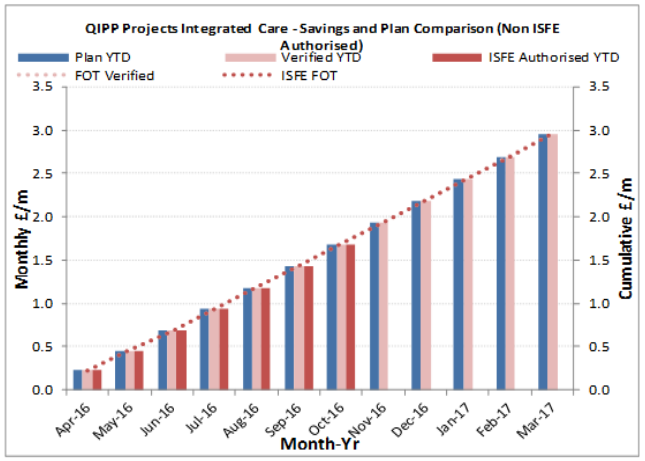
QIPP Programme Delivery Board - Validated Figures for Non ISFE

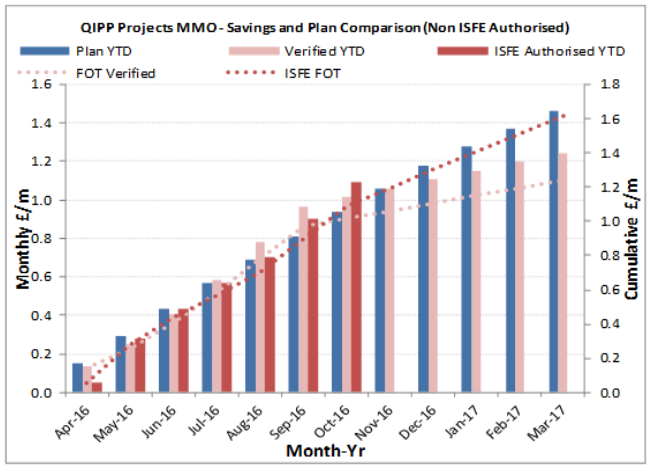
Reporting Period : **Oct-16**

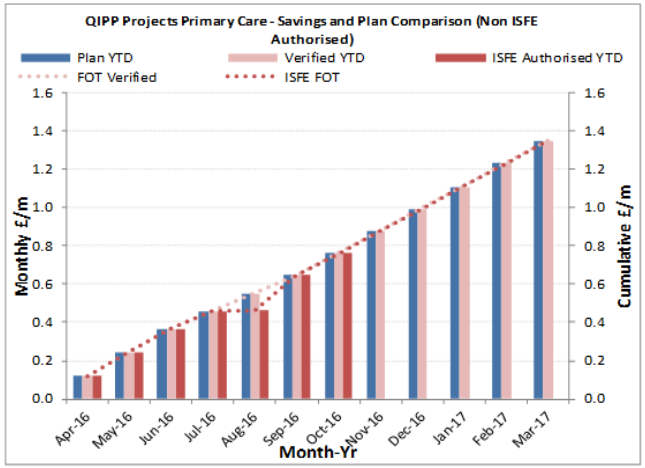
Financial Savings Projects within QIPP Programme Delivery Board and Annual Plan

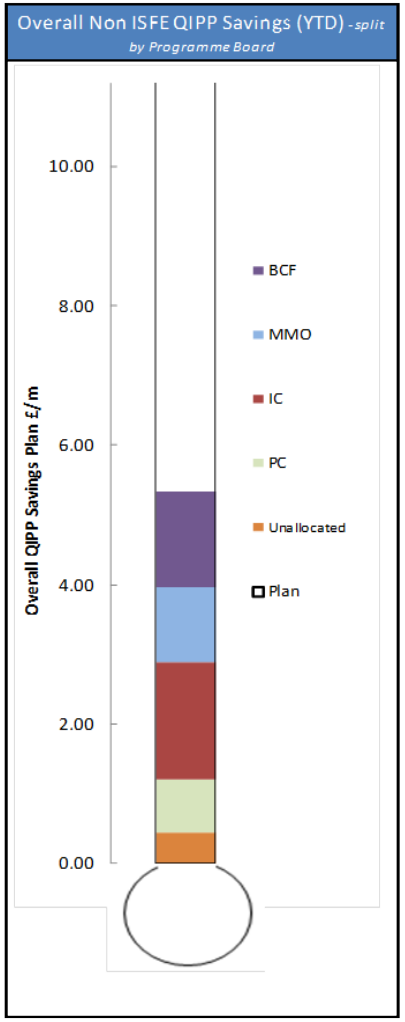
Source : Non ISFE Submission by Wolverhampton CCG - Financial Projects Only & BCF Dashboard











Note : Cumulative figures are based on a secondary axis

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

3. PERFORMANCE

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

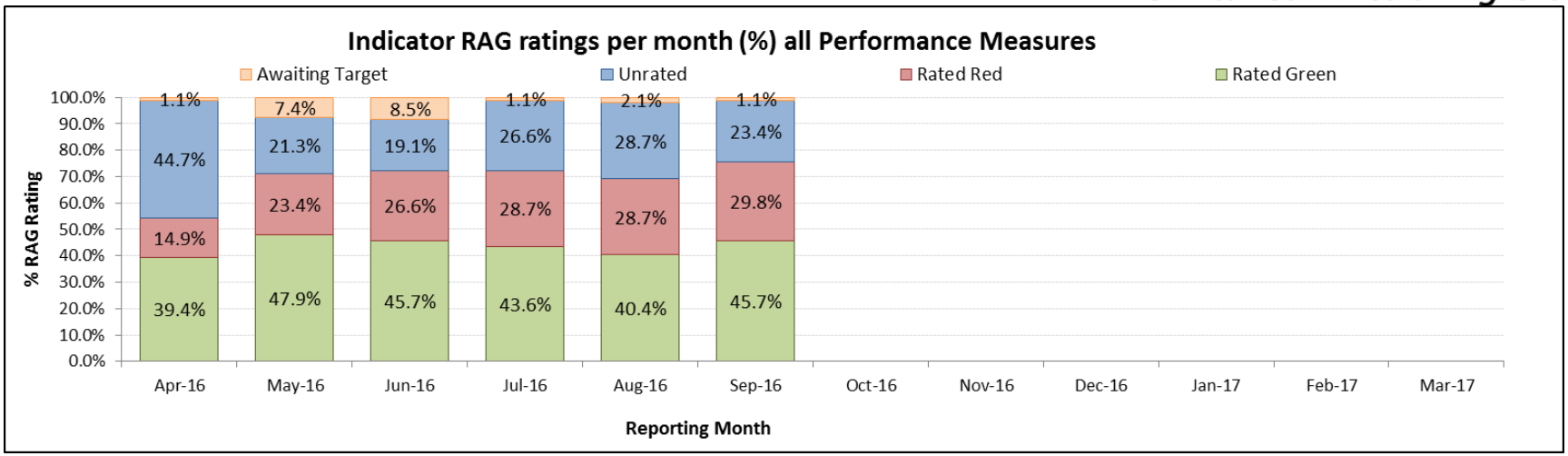
Executive Summary - Overview

Sep-16

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	No Submission (blank)	Previous Mth	Target TBC *	Total
NHS Constitution	11	11	11	11	2	2	0	0	**24**
Outcomes Framework	6	10	8	8	21	18	2	1	**37**
Mental Health	21	22	8	9	4	2	0	0	**33**
Totals	**38**	**43**	**27**	**28**	**27**	**22**	**2**	**1**	**94**

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	No Submission (blank)	Previous Mth:	Target TBC *
NHS Constitution	46%	46%	46%	46%	8%	8%	0%	0%
Outcomes Framework	16%	27%	22%	22%	57%	49%	5%	3%
Mental Health	64%	67%	24%	27%	12%	6%	0%	0%
Totals	**40%**	**46%**	**29%**	**30%**	**29%**	**23%**	**2%**	**1%**

* figures for Target TBC can vary month to month as the number of indicators not submitted (blank) for the month count will take priority. There are currently 4 indicators with targets yet to be agreed (3 of which had no data submitted for September 16)



Exception highlights were as follows;

Indicator Ref:	Title and Narrative	Yr End Target / Threshol
RWT_EB3	**Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral***	

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
91.50%	90.95%	91.04%	91.18%	90.45%								91.02%	92.00%

The performance data for headline level RTT (Incompletes) was not submitted by RWT on the SQPR at Month 6. At time of submission the Trust confirmed that this was due to "On-going validation" of waiting lists. The September data has since been updated on the RWT Integrated Quality and Performance Report (IQPR) as 91.22% and this has since been confirmed via the National Unify 2 submission as 91.22% with 3,053 (out of 34,790) patients waiting more than 18 weeks. The validated figures have also confirmed that Oral Surgery have met the 92% target for the first time this year with 92.60%. Recovery Action Plans (RAP) are updated by failing specialty on a monthly basis and the following specific actions have been identified : Utilisation of day case lists at weekends where possible, theatre utilisation to be reviewed at Cannock with the plan to transfer out additional Orthopaedic Lists, review of waiting list by procedure to support targeted lists and help with pre-op planning, plans for elective lists 6-4-2 weeks ahead; to anticipate issues and ensure lists are maximised and on-going work with the RTT team to forecast priority patients and identify bottle necks. The opportunity for additional (Urology) sessions, 2 days a week from January 2017 is currently being investigated by the Trust. CCG representatives attended an RTT Demand and Capacity Modelling Event (27th October) where NHSE presented an RTT overview presentation and demonstration of the Demand Management Tool. Main Points fed back from the event included: RTT Performance across the region is at 92.0% and so there is pressure building to try and tackle this now, before performance drops below threshold; Wolverhampton CCG is one of only four CCG's (across the BSOL, BC, C&W and H&W regions) to be fully compliant and meeting Best Practice for Demand Management Compliance against the 6 KLOE's, however, RWT is one of only four Trusts across the region to be failing. RTT at headline at the moment (excluding Walsall and Wye Valley). Early indications are that the October performance has seen an increase to 91.22%, however remains RED. The Commissioner performance has been confirmed for September as 91.38% (RED).

NHSE Updates: Strategic Demand Management Plan (DMP) submitted to NHSE to detail key issues and actions taken to improve performance including Outsourcing Plan and Demand Management Plan (DMP) incorporating best practice from Demand Management Good Practice Guidelines. The CCG are also working on a referral diversion project to look at how referrals can be appropriately diverted at point of referral.

Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test*

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
99.08%	99.19%	99.18%	99.01%	0.80%								79.45%	99.00%

RWT_EB4

The performance data for Diagnostic Tests was not submitted by RWT on the SQPR at Month 6. At time of submission the Trust confirmed that this was due to "On-going validation" of waiting lists. Data for Month 5, was updated as 0.80% against the 99% target. The CCG have liaised with the Trust as this is a significant change in performance trend for this indicator. It has been confirmed by the Trust that the August performance was submitted incorrectly and the correct figure is 99.2% and therefore GREEN.

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*

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
85.08%	88.03%	91.61%	88.63%	90.32%	93.86%							89.59%	95.00%

RWT_EB5

The A&E 4 Hour Wait performance has failed to meet the 95% national target since August 2015. The Month 6 performance has seen improvement and is the highest performance level so far this year (and since October 15) to 93.86% but has failed to achieve the STF recovery trajectory and both Type 1 and the combined All Types target for the month. The Quarter 2 performance has also failed to achieve target reporting at 85.76%. Updated Remedial Action Plans (RAP) are currently received monthly with the October updates on previous actions including : confirmation of full recruitment for surge capacity (qualified and unqualified nurses), 3 x Trust Fellows commenced the August rotation and the Trust have shortlisted 4 candidates for the Paeds ED Consultant posts. Following the advertisement for a Specialty Doctor there have been 2 candidates expressing interest. The Adult Consultant vacancies have been advertised during September/October. The additional B7 Senior Sisters post (for 24/7 cover) commenced on 1st October and the new Junior Doctors rota is in place (with 2 slots empty). A joint triage process has been incorporated from September to strengthen appropriateness of patient pathways and reduce unnecessary demand. An A&E Delivery Board consisting of Executive level membership (Acute, CCG, Local Authority and Black Country Partnership) has replaced the SRG and is supported by an A&E Operational Group with a main focus on the achievement of the 95% four hour target. Current performance shows encouraging signs and RWT are regularly performance above 90% combined for A&E. Maintaining performance over winter months will be challenging and a combined A&E Delivery Board RAP is being developed to maintain existing performance levels. The performance split for the time spent in ED (<4hrs) during September is as follows : New Cross = 89.79%, Walk In Centre = 100%, Cannock MIU = 100%, Vocare = 99.79% (Combined = 93.86%). Early indications are that the October performance has seen a decrease to 92.33% and remains RED.

NHSE Updates: Confirmation of non-submission on Urgent Care Centre data was requested by NHSE (7th November), investigation resulted in the identification of a coding error for the Wolverhampton Doctors Urgent Care.

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

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
93.30%	97.00%	96.41%	95.36%	95.63%	96.37%							95.68%	96.00%

RWT_EB8

Performance for Month 6 has met the 96% target reporting 96.37% in month, however the YTD remains below target at 95.68% due to low performance in April, July and August. There were 7 patient breaches in September (out of 193 patients). Analysis of the Year on Year performance shows performance is below that of 2015/16 for the same month (15/16 - 96.92%). Performance for this indicator has fluctuated over the last few months but has seen steady improvement since failing in July due primarily to capacity issues. Validated figures are received after the SQPR submission deadline as the final cancer figures are uploaded nationally 6 weeks after month end, however the validated figures for September confirm that the Trust achieved 96.9% (relating to 6 breaches out of 195 patients seen) and therefore is rated as GREEN. The position for Quarter 2 has also been confirmed as 96.3% and within target.

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

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
97.37%	91.11%	75.76%	89.47%	87.27%	89.36%							88.39%	94.00%

RWT_EB9

The performance for Month 6 has seen a small increase in performance since the previous month although remains under the 94% target at 89.36% which relates to 5 patients breaching the standard, the Trust have confirmed breaches were due to capacity issues within Urology. The YTD performance (88.93%) has also breached target. Performance for the previous 4 months has been significantly below that achieved for the same months in 2015/16. This indicator is affected by small cohorts of patients with a total of 47 patients seen in September (5 of which breached target). Validated figures are received after the SQPR submission deadline as the final cancer figures are uploaded nationally 6 weeks after month end. The validated figures for Q2 have now been confirmed as July - 92.11% (3 breaches, RED), August - 88.71% (7 breaches RED) and September - 91.67% (4 breaches RED). The total position for Quarter 2 has been confirmed as 90.54% and breaches target.

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

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
79.88%	72.02%	81.36%	79.77%	75.63%	80.13%							78.13%	85.00%

RWT_EB12

The performance in Month 6 has seen a slight increase in performance although remains below the 85% target both in month (80.13%) with 15 breaches (out of 78) and Year To Date (78.13%). The Trust have since confirmed via the Integrated Quality and Performance that there were 17 patient breaches in September (4 x tertiary referrals, 5 x capacity issues, 2 x patient initiated and 6 x complex pathways). Performance has failed to meet the STF Trajectory of 85.16% for the month. Analysis by Cancer site confirms the breaches are relating to : Breast (90.48%), Urology (82.61%), Haematology (66.67%), Upper GI (66.67%), Colorectal (66.67%), Head & Neck (50.00%) and Lung (40.00%). Both Gynaecology and Skin saw 100% of patients seen within standard during Month 6. The Trust have confirmed performance excluding tertiary referrals as 81.94% (RED). New breach allocation guidance regarding tertiary referrals has been published and is due to come into force from 1st October. The Trust have advised whilst in principle this is positive, given the revised guidance for recovery Trusts need to treat patients within 24 days, it is likely that performance may be affected by breaches occurring as a result of complex care patients. The validated performance figures have now been confirmed as : April - 80.95% (16 breaches RED), May - 71.75% (25 breaches RED), June - 83.16% (16 breaches RED), July - 82.2% (10.5 breaches RED), August - 74.2% (21 breaches out of 81.5 patients RED) and September (15 breaches out of 77.5 patients RED). The Quarter 2 performance has been confirmed as 79.14% and therefore remains RED. Early indications are that the October performance has seen a significant decrease to 70.00% and remains RED.

The Trust have indicated a reduced level of confidence to achieve the STF trajectory by end of Quarter 4 due to capacity and tertiary referral issues.

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

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
80.77%	96.88%	82.35%	84.00%	95.83%	76.92%							86.13%	90.00%

RWT_EB13

Performance in Month 6 has seen a significant decline from the previous month and has breached the 90% target both in month (76.92%) and year to date (86.13%). The SQPR submission indicated that there were 3 breaches (out of 13 patients), however the Trusts Integrated Quality and Performance reports has since confirmed that there were 4 breaches (3 x Tertiary referrals and 1 x complex case). The Trust have confirmed performance excluding tertiary referrals as - 84.62% (RED), and performance is impacted by small cohort of patients. The validated performance figures have now been confirmed as : April - 80.77% (2.5 breaches RED), May - 96.88% (0.5 breaches GREEN), June - 82.35% (1.5 breaches RED), July - 92.31% (1 breach GREEN), August - 95.65% (0.5 breaches GREEN) and September - 78.57% (3 breaches out of 14 patients RED). The Quarter 2 performance has been confirmed as 88.46% and therefore remains RED. Early indications are that the October performance has seen an increase to 80.00% however remains below target and therefore RED.
The Trust have indicated a reduced level of confidence to achieve the STF trajectory by end of Quarter 4 due to capacity and tertiary referral issues.

Zero tolerance RTT waits over 52 weeks for incomplete pathways*

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Threshold
0	0	100	64	53	51							268	0

RWT_EBS4

This indicator has breached the zero threshold for 52 week waiters for the fourth consecutive month with 51 patients recorded as waiting over 52 weeks at the end of September 2016. All breaches relate to Orthodontics. The Trust reported 100 waiters over 52 weeks in June which were identified following an in depth review of waiting list practices and have been working to reduce the numbers. An Action plan has been developed by the Trust to ensure all patients affected are seen as soon as possible. The Trust are currently ahead of trajectory with 51 patients remaining against a target of 53 in September. As Orthodontics is a specialised service commissioned by NHSE, sanctions cannot be enacted, however, the Trust have developed an action plan to review all affected patients. This indicator has breached the Year End target for 2016/17.
Additional Information : The National RTT data indicates that there were 10 x Non Admitted long waiters over 52 weeks at RWT in September for "Other" specialties and a further 2 x Non Admitted long waiters over 52 weeks for Trauma & Orthopaedics.

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

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
33.33%	50.00%	20.00%	60.00%	62.50%	62.50%							48.06%	50.00%

BCPFT_EH4

Performance for this indicator has remained above the 50% target for three consecutive months with September reporting at 62.50%, however due to below target performance during April and June, the Year End performance remains below target at 48.06%. The CVO to reflect a change to patients age span (14-65) has been completed and submitted to the Trust. Small number variations and high levels of DNA continue to effect performance for this indicator. This is a National indicator which the Area Team monitor performance directly from the Trusts Unify2 submissions.

Percentage of all routine EIS referrals, receive initial assessment within 10 working days

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
50.00%	87.50%	100.00%	100.00%	92.86%	83.33%							85.62%	95.00%

BCPFT_LQGE05

The performance for this indicator has failed to achieve the 95% target both in month (83.33%) and Year End (85.62%). Performance is affected by small cohort of patients and the September breaches relate to 2 patients breaching standard (out of 12). Both breaches occurred due to patients DNA (one patient with multiple DNA appointments). The service has reviewed the assessment process and discontinued the assessment clinics in order to be more flexible in offering appointments at venues more suitable and amenable to the individual client. This also allows flexibility for the clinicians availability. The Team have reviewed the assessment process and have implemented changes which appear to be improving access and waiting times - including a triage system and risk assessment to determine as to whether home visits can be instigated dependent on level of risk. The team is continually reviewing the high number of DNAs and exploring ways to reduce them, including contacting clients who DNA to establish the reasons why. If the team are able to address the reason for the DNA then alternatives can be offered to meet the patient need. The standard initial assessment letter has been amended to include the reason for offering early appointments to assist recovery as a lack of understanding regarding a quick initial appointment time may have impacted on DNA rates. Utilisation of text messages and calling new clients to remind them about their appointments continues as well as sending out appointment letters. The team aim to offer 100% of referrals an appointment for assessment to meet the 10 day target with the service delivering an assessment clinic and 3 initial assessment slots in Outpatient clinics which support the clients being seen within 10 days and thus being able to establish a care plan within 2 weeks.

Performance for all indicators (Month 6) has been attached for information (appendix 1)

4. CONTRACTING and PROCUREMENT

The Committee received the latest overview of the contract and procurement situation. The Committee noted the current position of the contract negotiations for 2017/18 and 2018/19. There were no significant changes to the procurement plan.

5. DRAFT FINANCIAL PLAN

The Committee received a summary outlining the key issues for the recently submitted draft financial plan.

6. RISK and MITIGATION

Risks	Potential Risk Value Mth06	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	43.27%
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	0.47	0.79	60.00%	0.47	18.23%
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	0.94	1.25	80.00%	1.00	38.50%
TOTAL RISKS	**2.54**	**3.54**		**2.60**	**100.00%**

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

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

Mitigations	Expected Mitigation Value Mth06	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	1.25	1.25	100.00%	1.25	48.08%
Delay/ Reduce Investment Plans	0.40	0.40	100.00%	0.40	15.38%
Other Mitigations	0.50	0.50	100.00%	0.50	19.23%
Mitigations relying on potential funding	0.39	0.45		0.45	17.31%
Actions to Implement Sub-Total	2.54	2.60		2.60	100.00%
TOTAL MITIGATION	2.54	2.60		2.60	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 M7 the CCG has already committed its Contingency reserve of £1.78m therefore this cannot be considered as mitigation.

The CCG has been advised that risk associated with NHS Property Services will be centrally funded in 2016/17.

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.

7. RECOMMENDATIONS

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

Name: **Lesley Sawrey**
Job Title: **Deputy Chief Finance Officer**
Date: **30th November 2016**

Performance Indicators 16/17

Current Month: Sep

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

16-17 Reference	Description - Indicators with exception 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 (A M J J A S O N D J F M Yr End)
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%	93.86%	R	89.59%	R	↑	
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%	93.62%	G	93.54%	G	↑	
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%	93.29%	G	95.08%	G	↓	
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%	96.37%	G	95.68%	R	↑	
RWT_EB9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery*	RWT	94%	89.36%	R	88.39%	R	↑	
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	99.75%	G	→	
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%	94.83%	G	97.47%	G	↓	
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%	80.13%	R	78.13%	R	↑	
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%	76.92%	R	86.13%	R	↓	
RWT_EBS1	Mixed sex accommodation breach*	RWT	0	0.00	G	4.00	R	↑	
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	→	
RWT_EAS4	Zero tolerance methicillin-resistant Staphylococcus aureus*	RWT	0	0.00	G	0.00	G	→	
RWT_EAS5	Minimise rates of Clostridium difficile*	RWT	3 (11 mths) 2 (mth 12) 35 (Yr End)	3.00	G	31.00	R	↑	
RWT_EBS4	Zero tolerance RTT waits over 52 weeks for incomplete pathways*	RWT	0	51.00	R	268.00	R	↑	
RWT_EBS7a	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes*	RWT	0	50.00	R	353.00	R	→	
RWT_EBS7b	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes*	RWT	0	0.00	G	19.00	R	↑	
RWT_EBS5	Trolley waits in A&E not longer than 12 hours*	RWT	0	0.00	G	0.00	G	→	
RWT_EBS6	No urgent operation should be cancelled for a second time*	RWT	0	0.00	G	0.00	G	→	
RWTCB_S10C	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE, as defined in Contract Technical Guidance	RWT	95%	95.61%	G	95.17%	G	↑	
RWTCB_S10B	Duty of candour	RWT	Yes	No	G	-	R	↓	
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%	99.75%	G	99.61%	G	↑	
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%	97.94%	G	97.18%	G	↑	
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%	95.10%	G	93.72%	R	↑	
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%	87.03%	R	84.56%	R	↑	
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%	5.90%	R	3.02%	G	↓	
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	→	
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	1.00	R	5.00	R	↓	
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	0.00	G	8.00	R	↑	
RWT_LQR7	Number of cancelled operations - % of electives	RWT	0.80%	0.23%	G	0.49%	G	↑	
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	→	
RWT_LQR14	Stroke - Percentage of patients who spend at least 90% of their time on a stroke unit	RWT	80.00%	91.18%	G	90.14%	G	↑	
RWT_LQR15	Stroke - Percentage of higher risk TIA cases are assessed and treated within 24 hours	RWT	60.00%	82.35%	G	73.22%	G	↓	
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	4.00	G	46.00	G	↑	
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	30.00	G	189.00	G	→	
RWT_LQR18b	Optimising Outpatient Follow-Ups - Paediatric Rheumatology and Paediatric Endocrinology patients receiving telephone follow up clinic ≥ 30 per month	RWT	30	44.00	G	152.00	R	↑	
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	8.00	G	25.00	R	↑	
RWT_LQR19a	Dressings - % formulary and exception compliance	RWT	98.00%	99.40%	G	99.55%	G		
RWT_LQR19b	Dressings - % spend via non FP10 supply route	RWT	98.00%	99.28%	G	99.41%	G		

16-17 Reference	Description - Indicators with exception 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 A M J J A S O N D J F M Yr End
RWT_LQR20	% Patients in receipt of TTOs within 4hours from the pharmacy receiving order	RWT	TBC	97.86%		97.05%	Awaiting Target	↑	
RWT_LQR24a	Dementia – FAIR - Percentage of patients aged 75 years and over to whom case finding is applied following an episode of emergency, unplanned care to hospital.	RWT	90.00%	100.00%	G	99.61%	G	↑	
RWT_LQR24b	Dementia – FAIR - Percentage of patients aged 75 years and over admitted as emergency inpatients identified as potentially having dementia or delirium who are appropriately assessed.	RWT	90.00%	100.00%	G	100.00%	G	→	
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%	98.82%	G	98.81%	G	↓	
BCPFT_EBS1	Mixed sex accommodation breach	BCP	0.00	0.00	G	0.00	G	→	
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%	95.45%	G	96.72%	G	↓	
BCPFT_EBS4	Zero tolerance RTT waits over 52 weeks for incomplete pathways	BCP	0.00	0.00	G	0.00	G	→	
BCPFT_DC1	Duty of Candour	BCP	Yes	Yes	G	-	G		
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	→	
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%	62.50%	G	48.06%	R	→	
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%	98.36%	G	93.08%	G	↑	
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	99.77%	G	↑	
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	→	
BCPFT_LQGE01b	Percentage of inpatients with a Crisis Management plan on discharge.	BCP	100.00%	94.12%	R	99.02%	R	↓	
BCPFT_LQGE02	Percentage of EIS caseload have crisis / relapse prevention care plan	BCP	80.00%	96.55%	G	87.67%	G	↑	
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	26.00	G	77.00	G	↑	
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%	62.50%	G	48.06%	R	→	
BCPFT_LQGE05	Percentage of all routine EIS referrals, receive initial assessment within 10 working days	BCP	95.00%	83.33%	R	85.62%	R	↓	
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%	93.76%	G	93.72%	G	↓	
BCPFT_LQGE07	Psychosis Medication Review - Percentage who have been prescribed and administered antipsychotic treatments for >12 months that have had an antipsychotic medications review in the previous 12 months.	BCP	85.00%	100.00%	G		G	↑	
BCPFT_LQGE08	% compliance with local antibiotic prescribing formulary, including if there is evidence of justifiable clinical reasons for deviation from set formulary. Minimum of annual confirmation of % of compliance with the antibiotic formulary. To submit the EPACT antibiotic prescribing data to commissioners. Results to be presented to Health Protection Board. Adverse trends in unavoidable antibiotic consumption.	BCP	95.00%	100.00%	G		G	↑	
BCPFT_LQGE09	Evidence of using HONOS: Proportion of patients with a HONOS score	BCP	95.00%	95.76%	G	95.36%	G	↑	
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	→	
BCPFT_LQGE11	Delayed transfers of care to be maintained at a minimum level	BCP	7.50%	18.55%	R	14.59%	R	↓	
BCPFT_LQGE12	Emergency up to 4 hours. % of assessments relating to referral within period	BCP	85.00%	90.43%	G	89.57%	G	↑	
BCPFT_LQGE13	Urgent (up to 48 hours). % of assessments relating to referral within period	BCP	85.00%	81.82%	R	82.85%	R	↓	
BCPFT_LQGE14	Routine (up to 28 days). % of assessments relating to referral within period	BCP	85.00%	98.71%	G	97.93%	G	↓	
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	→	
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	97.62%	R	→	
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	→	
BCPFT_DB01	Safeguarding – failure to achieve thresholds for specific indicators as detailed in the Safeguarding Dashboard.	BCP	Yes	No	R	-	R		
BCPFT_DB02	CAMHS - failure to achieve thresholds for specific indicators as detailed in the CAMHS Dashboard.	BCP	Yes	Yes	G	-	R		
BCPFT_DB03	IAPT – failure to achieve thresholds for specific indicators as detailed in the IAPT Dashboard.	BCP	Yes	Yes	G	-	G		
BCPFT_DB04	Dementia Data Set – failure to complete the Dementia Data Set	BCP	Yes	Yes	G	-	G		

Additional Information Dashboards

Current Month: Sep

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

RWT - Safeguarding

16-17 Reference	Description - Indicators with exception 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 (A M J J A S O N D J F M Yr End)
LQSG01	**Level 1 training for Safeguarding Children** - As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 1 Safeguarding Children competence. Over a three-year period, staff at level 1 should receive refresher training equivalent to a minimum of 2 hours	RWT	95%	97.40%	G	97.05%	G	↓	
LQSG02	**Level 2 training for Safeguarding Children** - As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of staff that have up to date Level 2 Safeguarding Children competence. Over a three-year period, professionals at level 2 should receive refresher training equivalent to a minimum of 3-4 hours.	RWT	85%	93.22%	G	93.15%	G	↓	
LQSG03	**Percentage of staff that have up to date Level 3 Safeguarding Children competence.** As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Over a three-year period, professionals should receive refresher training equivalent to a minimum of 6 hours (for those at Level 3 core this equates to a minimum of 2 hours per annum) and a minimum of 12-16 hours (for those at Level 3 requiring specialist knowledge and skill).	RWT	85%	80.42%	R	81.62%	R	↓	
LQSG04	**Level 4 training for Safeguarding Children** - As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of staff that have up to date Level 4 Safeguarding Children competence. Named professionals should attend a minimum of 24 hours of education, training and learning over a three-year period.	RWT	100%	100.00%	G	94.45%	R	→	
LQSG05	Safeguarding Children training for Board Level for Chief Executive Officers, Trust and Health Board Executive and Non-Executive Directors/members As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of Board Level Executives and non-executives who have up to date Safeguarding Children competence within three months of appointment. This will require a tailored package to be delivered which encompasses level 1, knowledge, skills and competences, as well as Board level specific as identified in this section.	RWT	100%	No Data	No Data		No Data		
LQSG06	**Level 1 training for Safeguarding Adults** - As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 1 Safeguarding Adults competence. Over a three-year period, staff at level 1 should receive refresher training equivalent to a minimum of 30 minutes.	RWT	95%	99.22%	G	98.76%	G	↓	
LQSG07	**Level 2 training for Safeguarding Adults** - As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 2 Safeguarding Adults competence. Over a three-year period, individuals at level 2 should receive refresher training equivalent to a minimum of 3-4 hours.	RWT	85%	93.18%	G	92.27%	G	→	
LQSG08	**Level 3 training for Safeguarding Adults** - As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Individuals moving into a permanent senior level post who have as yet not attained the relevant knowledge, skills and competence required at level 3, it is expected that within a year of appointment additional education will be completed. Percentage of eligible staff that have up to date Level 3 Safeguarding Adults competence. Over a three-year period, professionals should receive refresher training equivalent to a minimum of 6 hours (for those at Level 3 core, this equates to a minimum of 2 hours per annum), a minimum of 12-16 hours (for those at Level 3 requiring specialist knowledge and skill). NB: Existing RAP in place 15/16. This will be carried forward given that the trajectory runs until Dec 2016.	RWT	85% of staff who have training due in Qtr	80.00%	R	83.00%	R	→	
LQSG09	**Level 4 training for Safeguarding Adults** - As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Named Professionals staff groups. Named Professionals should attend a minimum of 24 hours of education, training and learning over a three-year period. This should include non-clinical knowledge acquisition such as management, appraisal, and supervision training. NB: to be undertaken within three months of appointment.	RWT	100%	100.00%	G	100.00%	G	→	
LQSG10	Safeguarding training for Board Level for Chief Executive Officers, Trust and Health Board Executive and Non-Executive Directors/members As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Percentage of eligible members who have up to date Safeguarding Adults competence to be undertaken within three months of appointment. This will require a tailored package to be delivered which encompasses level 1, knowledge, skills and competences, as well as Board level specific as identified in this section.	RWT	100%	No Data	No Data		No Data		
LQSG11	**% Staff with up to date Basic PREVENT Awareness Training Level 1** - As defined in the NHSE Prevent Training & Competencies Framework. Percentage of staff with up to date PREVENT competence. Basic Prevent awareness training should be repeated on a 3 yearly cycle to ensure that individuals are up to date with current procedures and contacts	RWT	300.00	76.00	G	TBC	TBC	↑	
LQSG12	**% Staff with up to date Basic PREVENT Awareness Training Level 2** - As defined in the NHSE Prevent Training & Competencies Framework Percentage of staff with up to date PREVENT competence. Basic Prevent awareness training should be repeated on a 3 yearly cycle to ensure that individuals are up to date with current procedures and contacts *1617 trajectory based on numbers of staff trained.	RWT	300.00	245.00	G	TBC	TBC	↑	
LQSG13	**% Staff with up to date Basic PREVENT Awareness Training Level 3 -** Level 3 and 4 have to be delivered by trained people as training is more specific. Must take place within 12 months of relevant staff commencing in role. As defined in the NHSE Prevent Training & Competencies Framework. Percentage of staff with up to date PREVENT competence. Organisations should issue an update/briefing on Prevent to staff that have attended WRAP annually (or more frequently if required).	RWT	85%	No Data	No Data		No Data		
LQSG14	**% Staff with up to date Basic PREVENT Awareness Training Level 4** - As defined in the NHSE Prevent Training & Competencies Framework Percentage of staff with up to date PREVENT competence. Level 3 and 4 have to be delivered by trained people as training is more specific. Must take place within 12 months of relevant staff commencing in role. Organisations should issue an update/briefing on Prevent to staff that have attended WRAP annually (or more frequently if required).	RWT	85%	No Data	No Data		No Data		

BCP - Safeguarding

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
BCP_LQSG01	**Level 1 training for Safeguarding Children** - As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 1 Safeguarding Children competence. Over a three-year period, staff at level 1 should receive refresher training equivalent to a minimum of 2 hours	BCP	85%	96.65%	G	96.73%	G	↓	
BCP_LQSG02	**Level 2 training for Safeguarding Children** - As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of staff that have up to date Level 2 Safeguarding Children competence. Over a three-year period, professionals at level 2 should receive refresher training equivalent to a minimum of 3-4 hours.	BCP	85%	84.85%	R	85.65%	G	↓	
BCP_LQSG03	**Percentage of staff that have up to date Level 3 Safeguarding Children competence.** As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Over a three-year period, professionals should receive refresher training equivalent to a minimum of 6 hours (for those at Level 3 core this equates to a minimum of 2 hours per annum) and a minimum of 12-16 hours (for those at Level 3 requiring specialist knowledge and skill).	BCP	85%	78.06%	R	80.94%	R	↓	
BCP_LQSG04	**Level 4 training for Safeguarding Children** - As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of staff that have up to date Level 4 Safeguarding Children competence. Named professionals should attend a minimum of 24 hours of education, training and learning over a three-year period.	BCP	100%	100.00%	G	100.00%	G	→	
BCP_LQSG05	Safeguarding Children training for Board Level for Chief Executive Officers, Trust and Health Board Executive and Non-Executive Directors/members As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of Board Level Executives and non-executives who have up to date Safeguarding Children competence within three months of appointment. This will require a tailored package to be delivered which encompasses level 1, knowledge, skills and competences, as well as Board level specific as identified in this section.	BCP	100%	100.00%	G	100.00%	G	→	
BCP_LQSG06	**Level 1 training for Safeguarding Adults** - As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 1 Safeguarding Adults competence. Over a three-year period, staff at level 1 should receive refresher training equivalent to a minimum of 30 minutes.	BCP	95%	96.65%	G	96.73%	G	↓	
BCP_LQSG07	**Level 2 training for Safeguarding Adults** - As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 2 Safeguarding Adults competence. Over a three-year period, individuals at level 2 should receive refresher training equivalent to a minimum of 3-4 hours.	BCP	85%	87.03%	G	86.38%	G	↓	
BCP_LQSG08	**Level 3 training for Safeguarding Adults** - As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Individuals moving into a permanent senior level post who have as yet not attained the relevant knowledge, skills and competence required at level 3, it is expected that within a year of appointment additional education will be completed. Percentage of eligible staff that have up to date Level 3 Safeguarding Adults competence. Over a three-year period, professionals should receive refresher training equivalent to a minimum of 6 hours (for those at Level 3 core, this equates to a minimum of 2 hours per annum), a minimum of 12-16 hours (for those at Level 3 requiring specialist knowledge and skill). NB: Existing RAP in place 15/16. This will be carried forward given that the trajectory runs until Dec 2016.	BCP	End Aug - 45% End Oct - 65% End Dec - 85%	71.39%	G	62.66%	G	↑	
BCP_LQSG09	**Level 4 training for Safeguarding Adults** - As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Named Professionals staff groups. Named Professionals should attend a minimum of 24 hours of education, training and learning over a three-year period. This should include non-clinical knowledge acquisition such as management, appraisal, and supervision training. NB: to be undertaken within three months of appointment.	BCP	100%	100.00%	G	100.00%	G	→	
BCP_LQSG10	Safeguarding training for Board Level for Chief Executive Officers, Trust and Health Board Executive and Non-Executive Directors/members As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Percentage of eligible members who have up to date Safeguarding Adults competence to be undertaken within three months of appointment. This will require a tailored package to be delivered which encompasses level 1, knowledge, skills and competences, as well as Board level specific as identified in this section.	BCP	100%	100.00%	G	100.00%	G	→	
BCP_LQSG11	**% Staff with up to date Basic PREVENT Awareness Training Level 1** - As defined in the NHSE Prevent Training & Competencies Framework. Percentage of staff with up to date PREVENT competence. Basic Prevent awareness training should be repeated on a 3 yearly cycle to ensure that individuals are up to date with current procedures and contacts	BCP	85%	96.65%	Target from Dec16 - 85%		Target from Dec16 - 85%	↓	
BCP_LQSG12	**% Staff with up to date Basic PREVENT Awareness Training Level 2** - As defined in the NHSE Prevent Training & Competencies Framework Percentage of staff with up to date PREVENT competence. Basic Prevent awareness training should be repeated on a 3 yearly cycle to ensure that individuals are up to date with current procedures and contacts	BCP	85%	96.65%	Target from Dec16 - 85%		Target from Dec16 - 85%	↓	
BCP_LQSG13	**% Staff with up to date Basic PREVENT Awareness Training Level 3 -** Level 3 and 4 have to be delivered by trained people as training is more specific. Must take place within 12 months of relevant staff commencing in role. As defined in the NHSE Prevent Training & Competencies Framework. Percentage of staff with up to date PREVENT competence. Organisations should issue an update/briefing on Prevent to staff that have attended WRAP annually (or more frequently if required).	BCP	85%	89.63%	Target from Dec16 - 85%		Target from Dec16 - 85%	↑	
BCP_LQSG14	**% Staff with up to date Basic PREVENT Awareness Training Level 4** - As defined in the NHSE Prevent Training & Competencies Framework Percentage of staff with up to date PREVENT competence. Level 3 and 4 have to be delivered by trained people as training is more specific. Must take place within 12 months of relevant staff commencing in role. Organisations should issue an update/briefing on Prevent to staff that have attended WRAP annually (or more frequently if required).	BCP	85%	No Data	No Data		No Data		

BCP - IAPT

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
BCP_1	Number of people who have been referred for psychological therapies	BCP	TBC	583	Awaiting Target	3014	Awaiting Target	↑	# # # # # #
BCP_26c	Number of active referrals who have waited more than 28 days from referral to first treatment/therapeutic session at the end of each quarter, as a % of Total waiting	BCP	TBC	13.1%	Awaiting Target	23.6%	Awaiting Target	↓	
BCP_32	The number of people who have entered (ie received) psychological therapies during the reporting period	BCP	366	489	G	2525	G	↑	
BCP_37	IAPT % Moving to recovery (national indicator)	BCP	50.00%	55.11%	G	53%	G	↑	
BCP_55	People who have entered (ie received) treatment as a proportion of people with anxiety or depression	BCP	15.00%	8.6%	G	8.6%	R	↑	
LQIA01	Percentage of people who are moving to recovery of those who have completed treatment in the reporting period	BCP	50%	55.11%	G	53.42%	G	↑	
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%	98.36%	G	93.08%	G	↑	
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	99.77%	G	↑	
LQIA04	Percentage achievement in data validity across all IAPT submissions on final data validity report [Target - >80%	BCP	80%	No Data	No Data	87.34%	G		
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	1.25%	1.67%	G	8.62%	R	↑	

BCP - CAMHS

16-17 Reference	Description - Indicators with exception 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
BCP_LQCA01	Percentage of children referred who have had initial assessment and treatment appointments within 18 weeks. This indicator will follow the rules applied in the 'Improving access to child and adolescent mental health services' reducing waiting times policy and practice guide (including guidance on the 18 weeks referral to treatment standard)' in 'Documents Relied Upon'	BCP	Q1 – N/A Q2 - 75% Q3 - 80% Q4 - 90%	80.00%	G	75.80%	G	↑	
BCP_LQCA02	Percentage of caseload aged 17 years or younger – have care plan (CAMHs and EIS)	BCP	80.0%	100.00%	G	100.00%	G		
BCP_LQCA03	Percentage of all referrals from paediatric ward/s for self-harm assessed within 12 working hours of referral	BCP	95.0%	100.00%	G	100.00%	G	→	
BCP_LQCA04	Every young person presenting with self harm or crisis seen within 4 hours regardless of setting.	BCP	100.00%	100.00%	G	100.00%	G	→	

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
GOVERNING BODY
13 December 2016

Agenda item 16

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group(WCCG) Audit and Governance Committee (AGC) - 15 November 2016**
Report of:	Jim Oatridge – Chair, Audit and Governance Committee
Contact:	Claire Skidmore – Chief Finance and Operating Officer
Governing Body Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	• To provide an update of the WCCG Audit and Governance Committee to the Governing Body of the WCCG.
Public or Private:	This Report is intended for the public domain.
Relevance to CCG Priority:	The AGC delivers its remit in the context of the CCG's priorities in order to provide assurance to the Governing Body of the robustness of system and process.
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	The AGC is accountable to the group's governing body and its remit is to provide the governing body with an independent and objective view of the group's systems, information and compliance with laws, regulations and directions governing the group. It will deliver this remit in the context of the group's priorities, as they emerge and develop, and the risks associated with achieving them. The AGC shall critically review the group's financial reporting and internal control principles and ensure

	that an appropriate relationship with both internal and external auditors is maintained.

1. BACKGROUND AND CURRENT SITUATION

1.1 Appointment of Committee Member
A report was presented to the Committee following the recruitment to the current vacant lay member position. The successful candidate has been appointed following Committee approval.

1.2 Internal Auditors Progress Report
The Internal Auditors Progress Report gave an update on the progress of internal audit work against the 2016/17 plan. Also presented were the Contract Management Report and the IT Risk Diagnostic Assessment and Benchmarking Report and recommendations and management actions were noted by the Committee.

1.3 Internal Audit Report – Audit Follow Up
The Internal Audit Follow Up Report was presented following the agreement to pick up the audit recommendations from the previous auditors. The majority of these recommendations have now been implemented and target dates are identified for the remaining actions (none of these are high risk items).

1.4 External Audit Update
A verbal update was given to the Committee, work is ongoing in preparation for the 2016/2017 audit.

1.5 Local Counter Fraud Specialist Progress Report
The Committee received an update from the local counter fraud specialist which detailed progress against the 2016/17 work programme.

1.6 Local Security Management
A report in relation to Security Management was presented to the committee and noted as work in progress. Policies are in final design stages in readiness for committee ratification.

1.7 Risk Register Reporting /Board Assurance Framework.
There is ongoing work in this area to redesign reporting and promote staff awareness of risk. This is being undertaken by the Director of Nursing.

1.8 Annual Governance Statement
Mr McKenzie presented to the Committee a report and template for the Annual Governance Statement that will need to be completed for the CCG.

1.9 Financial Control Environment Assessment Submission, update on actions
The report was provided to the Committee for information. Submissions have been made to NHSE as required.

1.10 Losses and Compensation Payments – Quarter 2 2016/17
No losses or special payments were reported in quarter 2 2016/17.The Committee were asked for approval for the disposal of a nil residual value asset. This was agreed.

1.11 Suspensions, Waiver and Breaches of SO/PFPS
There were no suspensions of SO/PFPs in quarter 2 2016/17.

1.12 Receivables/Payables Greater than £10,000 and over 6 months old
The Committee noted that as at 30 June 2016, there were 4 receivables and 18 payables over £10,000 and greater than 6 months old.

2. KEY RISKS AND IMPLICATIONS

2.1 The Audit and Governance Committee will regularly scrutinise the risk register and the Board Assurance Framework of the CCG to gain assurance that processes for the recording and management of risk are robust. If risk is not scrutinised at all levels of the organisation, particularly at Governing Body level, the CCG could suffer a loss of control with potentially significant results.

3. RECOMMENDATIONS

The Governing Body of Wolverhampton CCG is asked to:

- **Receive** this report and **note** the actions taken by the Audit and Governance Committee

Name: **Claire Skidmore**
Job Title: **Chief Finance and Operating Officer**
Date: **17 November 2016**

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NHS
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WOLVERHAMPTON CCG

GOVERNING BODY
13 DECEMBER 2016

Agenda item 17

Title of Report:	**Summary – Primary Care Joint Commissioning Committee 1 November 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
Governing Body 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 1 November 2016. The key points to note from the report are: 2.5 A CCG Members Meeting took place in October 2016 to focus upon how practices will be commissioned from 1 April 2017. 3.1 An application was presented to the Committee to close a branch site of Dr MK Pahwa and Partners at Park Street South, Wolverhampton. 3.2 The Committee approved the steps that will be required for the CCG to make an application for full delegation of Primary Medical Services in line with the intention set out in the Primary Care Strategy.

Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	To ensure the operations of the CCG align with, support and augment transformational change in the way services are delivered, via the Better Care Fund and co-commissioning of primary care services, to further the preventative and public health agenda and opportunities for early intervention and proactive care through greater integration.
Relevance to Board Assurance Framework (BAF):	Outline which Domain(s) the report is relevant to and why – See Notes for further information
• **Domain 5:** Delegated Functions	This report provides an update on the work of the Joint Commissioning Committee, through which the CCG exercises delegated functions for commissioning Primary Medical Services

1. BACKGROUND AND CURRENT SITUATION

1.1. The Primary Care Joint Commissioning Committee met on 1 November 2016. This report provides a summary of the issues discussed and the decisions made at those meetings.

2. PRIMARY CARE UPDATES

The Committee received the following update reports:-

2.1 **NHS England**
The Committee were updated on the Sustainability and Resilience Programme (GPRP) and stated that Local Teams (DCO) have been asked to confirm practice selections for the GPRP by 18 October 2016. Following a meeting with all CCGs and a large number of self-referrals, a list of over 220 practices was submitted to the Central NHS England Team.

2.2 In relation to Biannual Extended Access Data Collection, it was noted that Practices are now contractually required to submit an online return twice a year through the Primary Care Web Tool. This new module will set out what access to appointments the practice offers to patients either itself or through other arrangements, seven days a week.

2.3 **NHS England Finance Update**
A report was presented to the Committee to outline the Month 6 position for the Wolverhampton GP Services 2016/17 budget. It was confirmed that the allocation as of month 6 is £33.1 million. The forecast outturn is £33.1 million delivering a breakeven position.

2.4 **Wolverhampton CCG**
The Committee were updated on the 7 Task and Finish Groups which have been established to support the implementation of the Primary Care Strategy across Wolverhampton.

2.5 It was noted that a Members Meeting took place in October 2016, the meeting focussed upon how practices will be commissioned from 1 April 2017. The meeting was a useful forum to give practices an opportunity to ask questions and raise queries regarding new ways of working. Discussions continue to take place within the practice groups who are now reviewing the formalities of working together and looking to sign off Memorandums Of Understandings (MOUs).

2.6 **Primary Care Programme Board**
The Committee was informed that the Interpreting Procurement has now been completed and a report will be presented at the WCCG Governing Body Meeting confirming the successful bidder.

2.7 It was noted that it has been agreed to proceed with a joint Community Equipment Procurement with City of Wolverhampton Council.

2.8 **Primary Care Operations Management Group (PCOMG)**
The Committee noted that the CCG continue to work with NHS England on the Service Level Agreement and Specification for the Zero Tolerance Scheme.

2.9 Discussion took place around the Friends and Family Test Data submission and those practices who have not submitted data.

2.10 The Committee were informed that the CCG has received an approval notification regarding the Estates and Technology Transformation Fund (ETTF) for Cohort 1 in relation to GP IT bids.

3. OTHER ISSUES CONSIDERED

3.1 **Application to Close Branch Surgery**
An application was presented to the Committee to close a branch site of Dr MK Pahwa and Partners at Park Street South, Wolverhampton. Following discussion, the Committee agreed to accept the proposal to close the GP Branch Practice of Dr Pahwa. It was also agreed that NHS England would provide an addendum or revised business case to the December Committee on the progress of the previous business case and give further assurance on the support that would be available from the practice to patients during the closure. The Committee also requested further work to confirm the reason for the closure and a response to the patient petition concerns.

3.2 **Application for Full Delegation Responsibilities for the Commissioning of Primary Medical Services**
The Committee approved the steps that will be required for the CCG to make an application for full delegation of Primary Medical Services in line with the intention set out in the Primary Care Strategy and noted the application deadline of 5 December 2016.

3.3 The Committee met in private session to discuss an application received regarding a Practice joining the Vertical Integration second wave pilot project. Updates were also provided on a planned merger between Wolverhampton practices, the Wolverhampton CCG 2016/17 ETTF bids and the Basket Services Review.

4. CLINICAL VIEW

4.1. Not applicable.

5. PATIENT AND PUBLIC VIEW

5.1. Not applicable.

6. RISKS AND IMPLICATIONS

6.1. None arising from this update.

7. RECOMMENDATIONS

That the Governing Body Note the Report

Name Pat Roberts
Job Title Lay Member for Public and Patient Involvement, Committee Chair
Date: 18 November 2016

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	Date
Clinical View	N/a	
Public/ Patient View	N/a	
Finance Implications discussed with Finance Team	N/a	
Quality Implications discussed with Quality and Risk Team	N/a	
Medicines Management Implications discussed with Medicines Management team	N/a	
Equality Implications discussed with CSU Equality and Inclusion Service	N/a	
Information Governance implications discussed with IG Support Officer	N/a	
Legal/ Policy implications discussed with Corporate Operations Manager	N/a	
Signed off by Report Owner (Must be completed)	**Pat Roberts**	**18/11/16**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body – December 2016

Agenda item 18

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

1. BACKGROUND AND CURRENT SITUATION

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

2. PRIMARY CARE STRATEGY COMMITTEE

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

- Program of Work Delivery & Governance Arrangements
- New Models of Care
- General Practice Five Year Forward View

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

Task & Finish Group	Highlights
Practices as Providers	• Group met in October 2016 • Non-clinical support functions currently being explored & options appraisal to be shared • Emerging groups of practices are not aligned to the existing locality structure hence alternative arrangements for group level meetings are being explored • Meetings continue to take place with practices not yet aligned to a practice group (see appendix 1) • The Chairman is in the process of assembling regular meetings with Group Leaders in addition to meetings with Locality Leads • Primary Care Home presented at the National Primary Care Conference in October & were visited by the National Association of Primary Care which has led to a ministerial visit being planned imminently • Meetings with Commissioning leads for Mental Health (IAPT), Clinical Pharmacist Role and End of Life Care have taken place in relation to opportunities to improve team working & service delivery in Primary Care Home • Consideration of practice group working to provide extended opening are being explored within Primary Care Home

Localities as Commissioners	• Practice budget statements have been prepared & locality statements are intended to be shared at the next round of Locality Meetings • The enhanced services review has concluded, final queries regarding the formula attached to the costing template were anticipated to conclude shortly too • Consideration is being given to the potential to introduce a local Quality Outcomes Framework discussions with Group Leaders, Locality Leads, LMC and Commissioning colleagues were due to take place • Practice level dashboards have been introduced in Aristotle to assist practices in managing referrals, frequent attenders etc
Workforce Development	• Initial consultation on the draft Primary Care Workforce Strategy has concluded and amendments were being made • Workforce data was due to be reviewed following upload to the national tool • A new role, shared with Walsall CCG has been appointed to, funded by Health Education West Midlands (2 days per week) specifically for Clinical Educational Providers Network (CEPN) • A Primary Care Recruitment Fair Project Plan is being finalised and is due to be held early in the new year • A range of educational programmes has been launched by NHS England in response to the General Practice Five Year Forward View. Good engagement from practices has been observed.
Clinical Pharmacists in Primary Care	• The Task & Finish Group are due to meet at the same time as the committee meeting • National funding is still awaited, options to fund locally are being considered based on an initial needs analysis for each group of practices • Clinical Pharmacist role has been explained at both locality & members meetings since September to improve GPs understanding of the benefits of the role
General Practice Contract Management	• Preparation for full delegation continues following approval from the Governing Body in November • A task & finish group was due to meet later in November to review the impact on CCG teams/resource to ensure all reasonably foreseeable activities were considered and mitigated & a communication plan is in place to explain the changes • NHS England have shared their revised offer for the Primary Care Hub & the outcome of discussions was due to be fed into the Task & Finish Group mentioned

	above • Collaborative contract review visits have commenced in October, the effectiveness of these will be reviewed with participating practices & LMC at the end of March • The programme of work for the group has been revised & due to be approved by the group at its next meeting
Estates Development	• Bids for cohorts 1 & 2 have been successful • The Local Authority have appointed a Project Manager to create an overarching estates development plan for the CCG, RWT, BCP and local authority developments • The Local Estates Forum was due to take place & will be reported on in a subsequent report • Work is also taking place to understand the extent of development & cumulative effect on CCG revenue
IM&T	• A review of the DXS Service has concluded. Debate took place regarding the viability of the provision particularly for practices who were keen to use the service but couldn't • Clinical System Transfers continue to take place according to plan, including transfers for practices involved in mergers • Wifi project had been finalised, 22 practices are due to receive 10mb data lines

2.3. There were no escalated items for the committee to consider although there has been programme risks identified that were not thought to be high level corporate risks at this stage and would continue to be managed at task and finish group level.

2.4. The programme has been established since the summer there are a series of items that have been achieved many of which were reported to Governing Body in November, the programme of work is scrutinised by committee at each meeting to ensure the programme remains on track and delivers according to agreed timescale. The committee are satisfied with the extent of mobilisation that has occurred to date and has no concerns to share with the Governing Body at this stage.

3.0 NEW MODELS OF CARE

3.1 Discussions continue to take place with practices who are interested in aligning with their preferred new model of care. Appendix 1 confirms that latest practice numbers, many of which are working under an agreed Memorandum of Understanding although there are some practices observing caution who are yet to sign.

The Primary Care Team continue to work with those practices who are yet to confirm arrangements with their preferred model of care.

3.2 A further Project Manager has been appointed to work with the Medical Chambers group of practices in order to support them to progress in line with the CCGs

Programme of Work and respond accordingly to the projects currently being launched by NHS England in response to the General Practice Five Year Forward View.

3.3 The Ten High Impact Actions our groups are being supported to tackle are categorised as follows:-

1. Active Signposing
2. New Consultation Types
3. Reduce Did Not Attend (DNAs)
4. Develop the Team
5. Productive Work Flows
6. Personal Productivity
7. Partnership Working
8. Social Prescribing
9. Support Self Care
10. Develop Quality Improvement Expertise

The Primary Care Team continue to work in close liaison with NHS England to ensure work taking place locally is aligned to national requirements including scope, content and timescale. A detailed tracker is in place to monitor the launch and implementation of each project and responsive actions taking place locally.

3.5 The vertical integration/primary and acute care system model (PACs) is a collaboration between the Royal Wolverhampton Trust and a smaller cohort of general practices (see Appendix 1) transitions are currently being finalised for the second cohort of practices who are intending to sub contract their GMS contract(s) to the trust before the end of March 2017.

4 CLINICAL VIEW

There are a range of clinical and non-clinical professionals leading this process in order to ensure that the leadership decisions are clinically driven.

5 PATIENT AND PUBLIC VIEW

Whilst patients and the public were engaged in the development of the strategy and a commissioning intentions event held in the summer specific to primary care the Governing Body should note that Practice based Patient Participation Groups are being encouraged to ensure their work with the practice(s) encompasses new models of care and the importance of patient and public engagement moving forward.

6 RISKS AND IMPLICATIONS

Key Risks

6.1 The Primary Care Strategy Committee has in place a risk register that has begun to capture the profile of risks associated with the program of work. Risks pertaining to the program are reviewed at each meeting and at this stage there are no red risks to raise with the Governing Body.

Financial and Resource Implications

6.2 At this stage there are no financial and resource implications for the Governing Body to consider, representation and involvement from finance colleagues at committee and tasks and finish group level will enable appropriate discussions to take place in a timely manner.

Quality and Safety Implications

6.3 Patient safety is first and foremost, the experience of patients accessing primary medical services as the programme becomes more established is anticipated to be met with positive experiences of care. The quality team will be engaged accordingly as service design takes place and evaluation of existing care delivery is undertaken.

Equality Implications

6.4 The Strategy has a full equality analysis in place. This will require periodic review during the implementation phase.

Medicines Management Implications

6.5 The role of clinical pharmacist is an area of specific attention within the programme of work. A task and finish group has been established to ensure this role is utilised with maximum impact in the future.

Legal and Policy Implications

6.6 The Primary Care Strategy demonstrates how the CCG seeks to satisfy its statutory duties and takes account of the key principles defined within the General Practice Five Year Forward View.

7 RECOMMENDATIONS

The recommendations made to governing body regarding the content of this report are as follows:-

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

Name Sarah Southall
Job Title Head of Primary Care
Date November 2016

Enclosure New Models of Care Graphic

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	Date
Clinical View	Manjeet Garcha	28.11.16
Public/ Patient View	Pat Roberts	28.11.16
Finance Implications discussed with Finance Team	Claire Skidmore	28.11.16
Quality Implications discussed with Quality and Risk Team	Manjeet Garcha	28.11.16
Medicines Management Implications discussed with Medicines Management team	David Birch	28.11.16
Equality Implications discussed with CSU Equality and Inclusion Service	Juliet Herbert	28.11.16
Information Governance implications discussed with IG Support Officer	NA	
Legal/ Policy implications discussed with Corporate Operations Manager	Steven Marshall	28.11.16
Signed off by Report Owner (Must be completed)	Steven Marshall	28.11.16

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New Models of Care (Wolverhampton)

NHS
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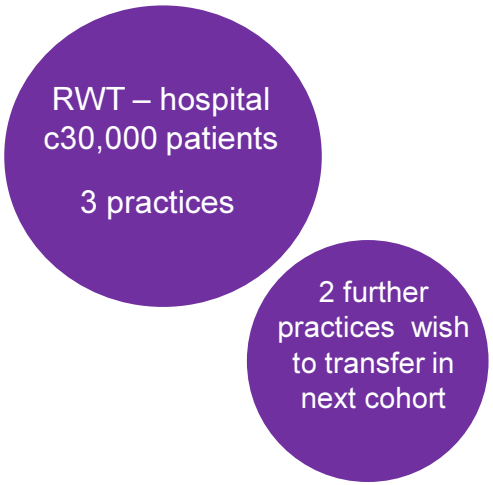
Multi-speciality Care Provider is a new deal for GP's as part of the 5 Year Forward View. This would take the shape of being a collaboration of a group practices i.e. federations, networks or single organisation(s). This is not only an opportunity to standardise back office functions and avoid replication but also a way of expanding leadership to include many healthcare professionals. Across the grouping there will be a collaborative approach to service provision whilst there will be a greater convenience for patients shifting the majority of outpatient consultations & ambulatory care out of hospital settings.

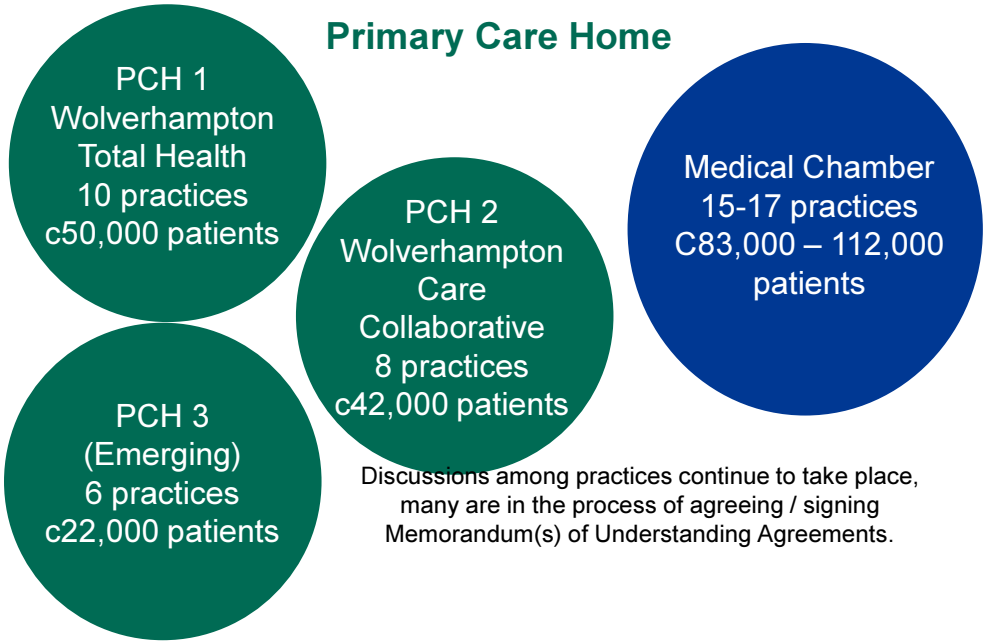
Primary & Acute Care Systems (PACs/VI) is a collaboration between NHS Trusts and GP Practices to meet the needs of registered list(s) of patients. This is an opportunities for trust's to kick-start primary care expansion but reinforce out of hospital care which could evolve into taking accountability for all health needs of a registered list of patients. Part of Vertical Integration is a greater level of back office support which will care of the business element of General Practice.

Vertical Integration (VI)



Primary Care Home is a joint NAPC and NHS confederation programme. Primary Care Home Model is based on care hubs/neighbourhood approach. Supported by the new models programme featuring provision of care to a defined, registered population between 30-50,000 people, function with an integrated workforce with a strong focus on partnerships spanning primary/secondary/social care, a combined focus on the personalisation of care with improvements in population health outcomes, alignment of clinical & financial drivers with appropriate shared risks and rewards.

Primary Care Home



Discussions among practices continue to take place, many are in the process of agreeing / signing Memorandum(s) of Understanding Agreements.

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NHS
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WOLVERHAMPTON CCG

Governing Body –13 December 2016

Agenda item 19

Title of Report:	**Communication and Participation update**
Report of:	Pat Roberts – Lay member for PPI
Contact:	Pat Roberts and Helen Cook, Communications & Engagement Manager
Communication and Participation Team Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	This report updates the Governing Body on the key communications and participation activities in November 2016. The key points to note from the report are: **2.1.1 Sustainability Transformation Plans (STP) – Better Health and Care – official launch of plan** **2.1.2 Stay Well this Winter campaign**
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 November, 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 Sustainability Transformation Plans (STP) – Better Health and Care

Work across the Black Country area to finalise our STP was completed, with the final plan launched 21 November with our colleagues from across the Black Country. For the full plan, the easy read version and FAQs please visit https://wolverhamptonccg.nhs.uk/your-health-services/better-health-and-care.

An event is planned for the public on the 6 December, the first in a series of engagement events across the Black Country for the public. Planning for the event is well underway as well as future public engagement events over the coming months spread across the whole of the Black Country area.

2.1.2 Stay Well this Winter– official campaign

The 2016/17 Stay Well This Winter campaign, jointly led by NHS England and PHE, was formally launched throughout England with a national TV, radio, print and online advertising campaign. The campaign aims to keep vulnerable people well through winter and reduce pressures on the NHS. The first phase of the campaign is being led by Public Health England and focusses on promoting free flu vaccinations for children aged 2-7, people over 65, those with a long-term health conditions - such as diabetes, stroke and heart disease – and pregnant women. Local campaigns are already under way and Stay Well

From 7 November the campaign moved into the winter phase. This part of the campaign will prepare the vulnerable for winter by giving advice on how to ward off common illnesses. It will urge those at risk to keep warm, get help from your pharmacist if you feel unwell and stock up on prescription medicines before pharmacies close for Christmas.

Locally, planning has been finalised for a joint winter campaign, 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.

Click the links to see local patients and a Practice Nurse having their flu jabs.
https://wolverhamptonccg.nhs.uk/your-health-services/stay-well-this-winter/flu-vaccination

https://wolverhamptonccg.nhs.uk/your-health-services/stay-well-this-winter - the CCG Stay Well webpages which will be updated with new information.

Posters and leaflets have been directly delivered to GP practices across the city and planning is underway to hold some public events to share the stay well and keep warm messages across the city.

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 latest edition of the Practice Nurse bulletin went out in mid November. Topics included: World Antibiotic Awareness Week, IT satisfaction survey, ORANGE Wolverhampton, Be Clear On Cancer campaign, offers for training: Trainee Nursing Associates, lunch and learn at Compton Hospice and information on the RCN new credentialing programme.

2.2.3 **Practice Managers Forum**
The November meeting discussed varied topics including:

- School Nursing Programme
- Member Practices featuring in the media
- Health Navigator Systems

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 via the Commissioning cycle has begun and it has been decided to have more interactive public engagement in the form of a week's events in week beginning 15th May 2017.

2.3.2 **PPG and Citizens Forum**
The November meeting is being informed of the Black Country STP prior to the launch meeting on 6th December and the CCG End of Life Strategy.

2.3.3 **Volunteers Policy**
A new policy for all CCG patient volunteers has been created and is being presented to the Quality and Risk Committee and will come to the Governing Body for ratification

3. LAY MEMBER MEETINGS

3.1.1 The Lay Member met with the Healthwatch Interim Chair, the new chair of Healthwatch and a Patient Engagement representative for RWT and discussed patient issues.

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 November 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**	**29 November 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	29 November 2016

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NHS
Wolverhampton
Clinical Commissioning Group

MINUTES OF THE QUALITY & SAFETY COMMITTEE HELD ON 11TH OCTOBER 2016, COMMENCING AT 10.30AM, IN THE MAIN CCG MEETING ROOM, WOLVERHAMPTON SCIENCE PARK.

PRESENT:	Dr R Rajcholan	-	WCCG Board Member (Chair)
	Steven Forsyth	-	Head of Quality & Risk
	Kerry Walters	-	Governance Lead Nurse, Public Health
	Marlene Lambeth	-	Patient Representative
	Pat Roberts	-	Lay Member Patient & Public Involvement
	Philip Strickland	-	Administrative Officer
	Juliet Herbert	-	Equality & Inclusion Business Partner
	Peter McKenzie	-	Corporate Operations Manager
APOLOGIES:	Jim Oatridge	-	Lay Member, WCCG
	Manjeet Garcha	-	Executive Director of Nursing & Quality

1. APOLOGIES & INTRODUCTIONS

Introductions were made and the above apologies were noted by members. Steven Forsyth was introduced as the new Head of Quality & Risk

2. MINUTES & ACTIONS OF THE LAST MEETING

2.1 Minutes of the 13th September 2016

The minutes of the meeting held on the 13th September 2016 were approved as an accurate record.

2.2 Action Log from meeting held on the 13th September 2016

The Action Log from the Quality & Safety Committee held on the 13th September 2016 was discussed, agreed and an updated version would be distributed with the minutes of this meeting.

3. DECLARATIONS OF INTEREST

No declarations of interest were raised.

4. MATTERS ARISING

No matters were raised by members.

5. FEEDBACK FROM ASSOCIATED FORUMS

5.1 Draft CCG Governing Body Minutes

PR highlighted that there was now a new lay member for Finance and Performance had been confirmed as Peter Price.

PR stated that as there was limited time allocated to patient stories at the Governing Body it was added that it may be beneficial to allocate allotted time at the Quality & Safety Committee. SF was in agreement that this indeed should form part of The Quality & Safety Committee in which a patient story could be provided and then at a following meeting feedback could be provided on the story.

ACTION: ***Patient Stories to be discussed at the Quality & Safety Committee on a monthly basis as they are received for discussion.***

PR highlighted that with regard to End of Life Care it would be beneficial to have a video presented at the next Quality & Safety Committee with regard to the 'Swan Project'.

ACTION: ***End of Life 'Swan' Project information video to be presented at the November Quality & Safety Committee.***

5.2 Health and Wellbeing Board Minutes

No minutes available at this time.

5.3 Quality Surveillance Group Minutes

No minutes available at this time.

5.4 Primary Care Operational Management Group (PCOMG)

The minutes of the 23rd August 2016 were noted by committee members. PR highlighted that it had been agreed that the CCG would be fully delegated by April 2017.

PR did wish to raise that there was a lack of collation of comments from the Friends and Family Test. It was very much driven purely around data. RR stated she would discuss with her practice manager at Ashmore Practice the process of where comments are fed back to.

RR highlighted from the minutes that RWT are planning to withdraw from the Ashmore, Bushbury and Pennfields sites as part of their estates rationale process. It was indeed raised at the PCOMG concerns around the safety of staff and practices and the vulnerability if they withdraw from these premises. It was also highlighted around the implications for the CCG as they will have to pay for any void costs. RR was unsure regarding the background to this? PR confirmed that this had formed part of a wider estates review that was currently on-going. PR stated she would gain further clarification and report back to the November meeting.

ACTION: ***PR to gain clarification regarding RWT planning to withdraw from the Ashmore, Bushbury and Pennfields sites.***

5.5 Clinical Commissioning Committee Minutes

The minutes of the 28th September 2016 were noted by the committee. RR raised from the minutes the decision to approve a business case for spinal surgery at Nuffield Health. PR stated that she would be raising this decision at the Governing Body for assurance due to the high risk nature of the surgery. SF also raised that there had not been 100% achieved on Nuffield Health WHO surgery checklist.

6. ASSURANCE REPORTS

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6.1 Monthly Quality Report

Royal Wolverhampton Trust

SF highlighted that RWT had reported a Never Event for the reporting period. SF stated he had given some significant challenge to this as a number of the staff involved did not have the suitable understanding of what constituted a Never Event. SF had looked for assurances of what would be put in place to ensure that this would not occur again. SF had enquired if a local surgical invasive procedure or policy existed and in this instance there had not been.

SF confirmed a reduction in Grade 3 pressure injuries however it was noted that there had been an avoidable grade 4. In the ward within which the grade 4 had occurred produced an action plan within 48 hours. SF stated he would be triangulating the data from the action plan with the safer staffing data to specifically look at Ward A7 due to poor leadership on that ward which had now been placed within special measures. PR highlighted that some litigation is now being encouraged by private solicitors following Pressure Injuries. SF confirmed that this was very much common practice by these specific firms.

SF confirmed that a stop clock had been requested following the Maternity Serious Incident reported on page 38 of the report which had been initially declined as more assurance was requested around the Did Not Attend Policy as this had indeed expired. Following an NPSA review the incident was graded as ‘zero’. SF confirmed that the Root Cause Analysis (RCA) would help to provide greater detail on this. Clarification was sought by committee members as to whether the baby concerned was indeed a new born. SF confirmed that he would clarify this information for the next meeting.

ACTION: ***SF to clarify the circumstance relating to the serious incident reported as 2016/25086***

With regard to incident 2016/25088 SF had requested further information regarding the level of paediatric skills of radiographer and also whether a lead for paediatrics existed in Radiography. SF stated that the main concerns in relation this incident had been, the handling of the child and the fact that a ‘crunch’ had been heard from the patient and this had not been reported and had only come to light through the complaint process. SF confirmed that he was waiting on the finer details from the RCA.

SF highlighted concerns in relation to overdue SIs that were dated back to 2015. SF believed that a more frequent fining system was needed as part of the contract for 2017/18

to help address this issue. SF stated he would be highlighting this to Debra Hickman the Deputy Chief Nurse.

SF confirmed a reduction in slips trips and falls and a full review of the associated policy following feedback from the falls audit that had been undertaken.

PR enquired why Never Events did not appear as part of the Serious Incident Reporting Profile? SF clarified that this formed part of the 'Surgical/invasive procedure incident meeting SI criteria' category. SF wished to note a discrepancy within the dashboard relating to 'Attempted Suicide by Outpatient' that was in fact a STEIS category incident - accident.

The committee noted that the RWT Safety Thermometer was indeed below trajectory however and improvement was now visible.

SF reported a decrease in complaints of 9.52%. RR enquired if this reflected both formal and informal complaints. SF confirmed his understanding is that this figure was purely in relation to formal complaints. PR highlighted a commendable improvement in the Trust handling of complaints following a period of encouraging patients to come forward and complains. This was noted as a result and impact of the new complaints policy developed by Alison Dowling, Patient Experience Manager at RWT.

RR raised from the report whether following the increase of the intake of mothers from the Walsall area this had affected the Friends and Family Test (FFT) data that showed that the percentage of *'not recommended'* data for post natal wards had increased by 6% from the previous month and the percentage *'recommended'* had also decreased. SF requested that this be raised at CQRM.

ACTION: ***SF to raise the FFT data at CQRM regarding Post Natal Wards following an increase of intake of Mothers from the Walsall area.***

Black Country Partnership Foundation Trust

SF confirmed there had been one SI to report (2016/24280) in which it appeared a patient had not been searched following permission to leave the premises and then return. SF confirmed that information from the RCA would help to clarify the finer details.

SF reported that the CQC are to conduct their re-inspection on the 17th October 2016. SF stated that he would be meeting with the CQC prior to the visit to highlight the areas of good practice and areas of concern.

PR questioned whether the only theme reported at the BCPFT CQRM in September had been Learning Disabilities? SF explained that this CQRM was themed by division and therefore CAMHS, Learning Disabilities and Working Age Adults. SF confirmed that a 4th theme had been proposed to include Older Adults. SF stated that the rolling themed programme did mean that some themes carried more weight and then therefore more content would be discussed one month to the next creating an in balance of discussion size. SF stated he had met with counterparts at Sandwell to then discuss having all the metrics at each CQRM meeting which in principal was agreed. SF did state however that he has since been told that perhaps this cannot be achieved. One further concern raised was indeed that the chair of the meeting also is done on a rolling programme. SF had volunteered to be the permanent chair for consistency purposes however that request had

also been declined. The committee agreed it would be beneficial for the CQRM to be a standalone meeting for Wolverhampton. It was highlighted that as part of the contract there should be 4 announced and 4 unannounced visits that take place as recommended in the national contract into each area however this only takes place across the whole Black Country area as opposed to individual areas. RR and PR were in agreement that this be raised with the contracting team as well as escalated to the Governing Body. PR reinforced the point by stating the importance of having these issues addressed before the next contracting round of discussions.

ACTION: ***SF to meet with the contracting team to discuss BCPFT CQRM issues from a procurement point of view.***

PR to escalate issues from the BCPFT CQRM, regarding the frequency and theming of the meetings and the use of a rotational chair to the governing body.

PR to escalate to the Governing Body the number of announced and unannounced visits undertaken across the Black Country area.

It was confirmed that as part of the Syrian refugee re-settlement programme 20 family are to be taken in to the local area.

Private Sector/Other Providers

SF confirmed that the NSL contract for patient contract would be ending imminently and would be replaced by WMAS.

SF confirmed that he would be attendance at the Heantun CQRM in the coming week within which discussion regarding the reporting structure and staffing would be discussed.

Quality Visits

RR questioned whether there would be any unannounced visits to RWT? SF believed there was great merit in conducting unannounced visits and would be looking into the possibility of conducting appropriate and responsive/proactive unannounced visits.

SF confirmed that the announced visit for A&E took place in September and proved to be a very useful visit. Some of the issues raised from the visit included poor signage on arrival, a lack of use of the Urgent Care Centre and a complicated pathway. It was confirmed that at present there were no outstanding Nursing Vacancies and only 2 medical positions outstanding. PR added that it had been raised at the Patient Participation Groups that there is indeed poor signage for patients.

It was confirmed that at the time of the visit there had been a large chemical spillage in Bilston which in turn meant that there was a large draw upon resources. SF commended the staff in A&E for the way within which it was handled.

RR questioned when the Never Event Assurance visit would be taking place as detailed in the Visit Schedule? SF stated he would confirm the visit with Annette Lawrence.

PPIGG

PR raised an issue from various practices regarding the use of Information Governance within practices. One example provided was in relation to the use of open emails as opposed to blind emails to private email addresses. SF stated he would raise this issue with Liz Corrigan in the Quality Team.

Complaints

Data from NHS England reported 13 complaints, most related to clinical incidents around medication and misdiagnosis. RR wished to highlight that from the data provided it didn't appear to highlight a significant amount of lessons learned.
ACTION SF to liaise with LC to highlight to NHSE the committee's views.

PR stated that there was a wider issue of patient confidence in coming forward to complain in practices as well as requesting same day appointments. It was highlighted that receptionist do attempt to triage patients particularly for those requesting same day appointments.

6.2 Safeguarding Adults Quarterly Report

SF reported that Annette Lawrence was unable to attend the meeting but highlighted that the Safeguarding Annual Report was included in the submitted document for committee members to read. It was suggested that any comments could be fed back to Annette via email.

It was highlighted that there was to be a prevention event planned for the 14th February 2017 regarding 'Feeling Safe and keeping well in Wolverhampton' as organised by the Safer Wolverhampton Partnership and the Health & Wellbeing board, SF requested that this be advertised through committee members various networks.

It was confirmed that Multi-agency policy & procedures for the protection of adults with care and support needs in the West Midlands (2016) was currently being signed up by 14 Safeguarding Adult Boards across the region, which was deemed by the committee as significant.

SF reported that DoLs referrals continue to increase and there is a local and national back log. It was confirmed that of the backlogged patients there are 12 CCG funded patients (i.e. Continuing Healthcare or Step Down) that had requested a DoLs but not had a DoLs. 5 were reported from RWT and 3 of those referrals were classed as inappropriate. There were also 3 DoLs referrals from the Black Country. 20 were reported from the CCGs commissioned services of which 3 were deemed as inappropriate.

SF confirmed that the Safeguarding Adult Review had been published.

https://www.wolverhamptonsafeguarding.org.uk/safeguarding-adults/safeguarding-adults-board/serious-case-committee-dhrs-sars

6.3 Information Governance Quarterly Update

Peter McKenzie was in attendance to present the Information Governance Quarterly Report. PM reported that there had been a number of recruitment and staffing issues at Arden & Gen since they undertook the contract for Information Governance on behalf of the CCG.

PM stated that the Fair Processing Notice is made publicly available to ensure the CCG meets its requirements to provide individual patients and the wider public with details of how the CCG uses information. It was confirmed that all information is reviewed as good practice on a 12 month basis and is available on the CCG website.

PM highlighted the IG work plan that was an appendix as part of the submitted report. As part of the IG Toolkit Compliance the key priorities include Staff Training, with 3 sessions arranged until the end of the Calendar year for staff. Online training was also reported as available through NHS digital. All work that formed part of the work plan was reported as on track. The IG toolkit is to be submitted by March 2016.

PR questioned who holds responsibility for IG for GP practices? PM stated that GP practices have their own data controls and they complete their own IG toolkit submission; however there is a contract in place from NHS England for Midlands and Lancashire CCGs to support GP practices. PM confirmed that this may change as the CCG moves towards full delegation.

6.4 Freedom of Information Report

PM confirmed that since the last report was submitted to Quality & Safety Committee the Freedom of Information Service had been brought back in house at the CCG. As a result it was confirmed that there had been a significant improvement in performance. It was confirmed that for the last quarter the CCG was performing at 98% in responding within the 20 day deadline. PM stated that th e organisation is working hard to get to 100% response target. Were the CCG is not hitting the target it is missing it by a couple of days and no complaints have been passed to the information commissioner.

PR questioned whether or not the CCG had received any requests regarding the STP. PM confirmed that there had been requests received regarding STP to the CCG.

6.5 Equality & Inclusion Update

Juliet Herbert was in attendance to present the Quarterly Equality & Inclusion update for period July to September 2016. JH wished to gage any feedback from the Equality Delivery System 2 (EDS2) Implementation plan for 2015/16. JH explained that EDS2 was a tool designed to help NHS organisations, in partnership with local stakeholders, to review and improve their performance for people with characteristics protected by the Equality Act 2010, and to support them in meeting the Public Sector Equality Duty. JH confirmed that at the heart of EDS2 were 18 outcomes which organisations can grade them against. The 18 outcomes are built out of 4 main goals including:

- Better Health Outcomes
- Improved Patient Access and Experience

- A representative and Supported Workforce
- Inclusive Leadership

JH confirmed that as a CCG the organisation needed to be evidencing that it is meeting its duties in line with EDS2. JH highlighted to the committee the submitted Action Plan which oversees the progress of the EDS2 work. It was confirmed that the deadline for the EDS2 work was the 31st March 2017. JH wished to develop an Equality and Diversity Task & Finish Group with specific leads responsible for individual areas of EDS2. PR stated that it was difficult for this committee to identify specific leads on someone else's behalf.

SF requested that some of the comments boxes within the Action Plan required some greater narrative.

6.6 National Report & Inquiries

SF commended the report as an excellent piece of work and stated that perhaps this report could be published.

SF confirmed that the submitted report provided an update from the Goddard inquiry and a 'Time to Listen'.

7. ITEMS FOR CONSIDERATION

No items were raised for consideration

8. POLICIES FOR CONSIDERATION

No policies were submitted ratification.

9. ITEMS FOR ESCALATION/FEEDBACK TO CCG GOVERNING BODY

It was agreed that the issue pertaining to the structure of the BCPFT CQRM should be escalated to the Governing Body.

10. ANY OTHER BUSINESS

No items were raised by committee members.

11. DATE AND TIME OF NEXT MEETING

- ***Tuesday 8th November 2016, 10.30am – 12.30pm; CCG Main Meeting Room.***

Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
COMMISSIONING COMMITTEE

Minutes of the Commissioning Committee Meeting held on Thursday 27th October 2016 commencing at 1.00 pm in the Main CCG Meeting Room, Wolverhampton Science Park

MEMBERS ~

Clinical ~		**Present**
Dr J Morgans	Chair	Yes
Patient Representatives ~		
Malcolm Reynolds	Patient Representative	Yes
Cyril Randles	Patient Representative	Yes
Management ~		
Steven Marshall	Director of Strategy & Transformation (Chair)	Yes
Claire Skidmore	Chief Financial Officer	Yes
Manjeet Garcha	Executive Lead Nurse	Yes
Juliet Grainger	Public Health Commissioning Manager	Yes
In Attendance ~		
Arun Sharma	Senior Contract Manager (Arden & GEM CSU)	Yes
Wendy Ewins	Lead Commissioner – Adult Learning Disabilities	Yes
Fred Gravestock	CAMHS Transformation Lead	Yes
Peter McKenzie	Corporate Operations Manager	Yes

Apologies for absence

Apologies were submitted on behalf of Vic Middlemiss.

Declarations of Interest

CCM536 There were no declarations of interest on this occasion.

Minutes

CCM537 It was noted that Claire Skidmore's apologies were noted twice. Other than this, the minutes of the last Committee, which took place on Wednesday 28th September 2016 were approved as true and accurate.

RESOLVED: That the above is noted.

Matters Arising

CCM538 In response to a query about physiotherapy services provided by Nuffield, it was confirmed that the service commissioned was for non-complex needs and complex needs would be referred to RWT as appropriate.

In response to comments relating to whether equipment was provided by the Nuffield it was agreed that the contract would be checked.

RESOLVED: That the contractual position in relation to equipment position be determined and reported to the committee's next meeting.

Wendy Ewins joined the meeting

Redesign of Learning Disability Assessment and Treatment Service

CCM539 The Committee considered the report from Wendy Ewins, which outlined the results of a public consultation exercise jointly undertaken by the CCG and Black Country Partnership Trust on relocating assessment and treatment provision for learning disabilities to alternative sites across the Black Country.

It was reported that the committee had previously agreed, in principle, to the relocation of services from Pond Lane, which had been significantly underused both due to the unsuitability of the physical environment and increased use of community based services. This reflected a national drive away from hospital based services, other than for clients in the greatest need.

In response to a query, Wendy Ewins confirmed that, whilst Pond Lane had previously been used to provide respite services, over the previous 10 years, hospital admission was no longer considered an appropriate respite service. Other community respite services were in place across Wolverhampton.

In response to further queries, it was confirmed that the alternative services identified were clinically appropriate and would provide additional benefits, including the ability to provide single sex accommodation. It was also confirmed that the building at Pond Lane would continue to be used by the Trust for other services and that the Trust were working with the staff affected. Wendy Ewins briefly outlined the regular, narrative reporting to NHS England on patients admitted to hospital to confirm that this ensured that the clinical

efficacy of the alternative provision would be regularly monitoried.

The Committee discussed the public consultation, noting that the nature of the service provided made it difficult to engage with patients. The most significant concerns that had been raised related to transport and it was noted that, where transport needs would be a significant factor for parents and carers, this would be taken into account in Care and Treatment planning and review processes. The involvement of experts by experience in these processes ensured that patient needs were kept at the centre of the planning process.

RESOLVED: That the Committee recommend that the Governing Body agree to the relocation of three inpatient beds from Pond Lane to other sites across the Black Country, namely Orchard Hills, Penrose and Daisy Bank.

Wendy Ewins left the meeting

Contract and Procurement Update

CCM540 The Committee received the regular monthly update in relation to contract performance and procurement. The report highlighted that Recovery Action Plans (RAP) remained in place for RWT for A&E, E-discharge and Cancer 62 day waits and that performance in gynecology had met the appropriate improvement target and the RAP had been stood down. A RAP for Black Country Partnership, in relation to PREVENT training, remained in place and issues with safeguarding training were under discussion. Details of performance sanctions for Month 4 were included in the report and Claire Skidmore advised that Month 5 sanctions had been at a similar level and would be reported to the next committee meeting. Cumulative sanctions for the year were around £186,000.

The Committee discussed a number of performance issues in relation to A&E, including ambulance handovers. It was noted that RWT had positive working relationships with the ambulance service and worked to minimise delays on handover. Steven Marshall also highlighted that the CCG had commissioned additional geriatrician and advanced nurse practitioner services within A&E to support effective and appropriate treatment of frail elderly patients conveyed to A&E in ambulances. It was agreed that the trust would be asked to clarify how these services, along with a proposed cardiology in reach service, were being deployed. It was also noted that the CCG's overall commissioning strategy aimed to ensure that appropriate services were in place in the community to prevent patients from reaching the point where they needed to be conveyed to A&E. It was reported that coding issues identified in A&E at RWT had now been resolved and a rebate would be received through the reconciliation process. Queries in relation to consultant to consultant referrals had been raised with the Trust and their initial response was that this activity was cost neutral. The Chair highlighted that further work would be required on this issue and it was agreed that there would be further investigation.

It was reported that, in line with national planning guidance, contract negotiation had commenced in order to reach a point where a two year

contract would be signed by 23rd December 2016. It was noted that, whilst this was a challenging timescale, work had begun and was currently on track. The Committee noted that there had been an error in the report and, whilst Sandwell and West Birmingham CCG would lead on the negotiation process, the CCG would have their own contract with Black Country Partnership and not be an associate.

Following an analysis of activity at the GP led urgent care centre operated by Vocare, the CCG had advised that the contractual provisions in relation to underactivity would be enforced. Vocare had queried this, highlighting issues with RWT services, including a see and treat clinic in the emergency department. The committee discussed these issues, and agreed that the management team would investigate the issue and report back to the committee.

The Committee were also advised that the CCG had received a request from another CCG to join the CCG's contract with Nuffield as an associate. It was agreed that queries in relation to the administrative burden associated with the request would be considered and reported back to the committee.

RESOLVED: That

- RWT be asked to clarify the position in relation to commissioned services for geriatricians, advanced nurse practitioners and the Cardiology In-reach service in A&E
- Further investigation of Consultant to Consultant referral patterns take place
- Management be asked to investigate service delivery models in the Emergency Department
- The request to join the CCG's contract with Nuffield be considered in more detail
- The report be noted.

Arun Sharma left the meeting
Fred Gravestock joined the meeting

Wolverhampton Children and Young People's Mental Health and Wellbeing Local Transformation Plan

CCM541 The Committee considered the report from Fred Gravestock, which introduced the refreshed Children and Young People's Mental Health and Wellbeing Local Transformation Plan (LTP). It was reported that the plan had originally been developed in October 2015 as part of the application for the Future in Mind Programme and, as part of NHS England's ongoing assurance arrangements, needed to be updated by 30 October 2016.

The LTP outlined the CCG's plans for overall system transformation and gave details of how the CCG planned to spend the £532,047 Future in Mind funding allocated. In response to a query from Claire Skidmore, Fred Gravestock confirmed that additional detail on finances would be included in the final plan.

Juliet Grainger highlighted that the plan did not reflect the contribution of voluntary sector services, including those commissioned by public health and Fred Gravestock acknowledged that further discussions with public health colleagues were required as part of the ongoing planning processes.

In response to further queries, it was confirmed that the LTP aimed to transform the approach from a focus on planning around tiers of service delivery to ensuring that pathways enabled an appropriate focus on individual children's needs.

RESOLVED: That the refreshed Children and Young People's Mental Health and Wellbeing Local Transformation Plan be approved, subject to Appendix G being updated.

Any Other Business

CCM542 The was no other business on this occasion

Date and Venue of Next Meeting

CCM543 Thursday 24th November, CCG Main Meeting Room

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

Minutes of the meeting held on 25th October 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 Jim Oatridge	Independent Committee Member

In regular attendance:

Mr G Bahia	Business and Operations Manager
Mr V Middlemiss	Head of Contracting and Procurement
Mrs L Sawrey	Deputy Chief Finance Officer

In attendance

Mrs H Pidoux	Administrative Team Manager

1. Apologies

Apologies were submitted by Mr Hastings

2. Declarations of Interest

FP.16.101 There were no declarations of interest.

3. Minutes of the last meeting held on 27th September 2016

FP.16.102 The minutes of the last meeting were agreed as a correct record.

It was noted that the membership listed on the reverse of the agenda is incorrect. It was agreed to add a note stating that an application to make changes to the CCG's Constitution includes the change to the membership of this Committee. The amendment would be made once the application has been accepted. Mr Oatridge requested his name to be removed from the membership going forward and for Mr Price's name to be added. It was agreed that it would be checked that this was included in the application for change.

4. Resolution Log

FP.16.103

- Item 92 (FP.16.96) – A fuller update on the reasons for the slippage against targets to be included in next month's report, together with an update on progress against future QIPP plans - Mr Price stated that he was interested in learning taken from the reasons for slippage and that this is taken into account when planning for next year. It was agreed that learning could be taken around risk share and co-dependencies – action closed.

5. Matters Arising from the minutes of the meeting held on 27th September 2016

FP.16.104 There were no matters arising from the previous minutes.

6. Finance Report

FP.16.105 Mrs Sawrey reported on the Month 6 financial position, stating that again the financial target had been hard to achieve and there is no more flexibility in the finance position.

It was noted that the only material variance in the acute contracts at Month 6 related to forecast overperformance at RWT. A review of RWT Community Services has enabled an underspend to be reported for the first time. Adjustments have been factored in to reflect the closure of a ward at West Park and recruitment slippage in the Rapid Response Nursing Team.

Mrs Sawrey stated that the Better Care Fund Forecast Outturn at Month 6 shows an overspend of £1,072m. The position reflects the growth in cost and activity in adult placements and a correction to system errors in reporting by the Local Authority. The Committee was informed that Mrs Skidmore is discussing audit options with senior Local Authority Finance colleagues to ensure there are not further repeats of system errors.

A question was raised in Appendix 4 of the report in relation to the statement of financial position as at 30th September 2016 where a movement of £2.3m was reported for receivables. Mrs Sawrey agreed to circulate a description of the movement to Committee members

Mrs Sawrey gave a QIPP Board update and reported a slight improvement with the 'unallocated QIPP' gap now £1.36m

Resolved: The Committee;

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

7. Performance Report

FP.16.106 Mr Bahia highlighted that of the indicators for Month 5, 38 are green rated, 27 are red rated, 27 are unrated and 2 are awaiting target.

The meaning of the 'unrated' title was discussed and it was agreed to have to separate headings to clarify this, 'unvalidated' and 'target awaited'. Mr Bahia was asked to give clarification as to why there were two measures awaiting target.

It was requested that the format of the report be further modified to focus on the priority areas for consideration and highlight where action should be considered by the Committee to improve these areas.

The following key points from the report were discussed;

- RTT - failing to meet target in General Surgery, Gynaecology, Orthopaedics, Plastic Surgery and Urology. The CCG is coming under increased scrutiny from NHSE regarding over performance activity.

  A submission was made to NHSE relating to RTT and it was agreed to share this submission with the Committee.

  It was suggested that as part of the report a monthly profile by speciality should be included to give a visual representation of the situation.

  Discussion took place regarding how it is possible to encourage the Trust to outsource to an alternative provider. A reminder was given that last year money was offered to the Trust to do this but this was not taken up. It was agreed to look at how to proactively encourage switching to an available provider.

- A&E – although target has been missed in line with the STF trajectory an improvement in performance has been seen. An updated RAP received has included actions to address staffing issues. Combined reporting with Vocare/Urgent Care Centre commenced on 1st September. The System Resilience Group has been replaced by an A&E Delivery Board to address these issues.

- 62 day cancer waits – new guidance has been received relating to how apportion breaches. A Trust has 38 days to pass on to another provider and the receiving Trust has 24 days to receive, see and treat the patient.

- Mixed Sex Accommodation – this indicator has breached the zero target both in-month and Year end with 4 breaches in August. A Root Cause Analysis has been undertaken and the

results will be discussed as part of the Clinical Quality Review Meeting (CQRM). Sanctions are applicable for each individual breach.

- RTT waits over 52 weeks for incomplete pathways – this zero threshold has been breached for the third consecutive month, all breaches relate to orthodontics. However, performance is slightly ahead of the planned recovery trajectory.

- BCPFT – Percentage of all routine EIS referrals, receive initial assessment within 10 working days – performance has failed to achieve target both in month and Year End. Performance is affected by the small cohort of patients. The assessment process has been reviewed and changes implemented, to triage system and risk assessments, appear to be improving access and waiting times. Text messages and calls to new clients reminding them of appointment details has been implemented in addition to sending out appointment letters. 'Did not attends' are also being reviewed, including contacting clients to establish the reason they did not attend to try and address this problem.

- C Diff – The Trust breached the national threshold in September. It was noted that the anti-microbial prescribing post funding has been approved.

- E-discharge – an improvement has been seen across all ward in September and the target has been met. However, assessment units continue to fail to meet the target. At the CQM and CQRM meetings this was discussed and it was agreed to benchmark against other Trust to assess if it is possible to achieve the target.

- Optimising Outpatient Follow-Ups – current performance has been raised with the Trust and feedback is awaited from the operational teams.

The Committee's attention was brought to the inclusion in the report of indicators which, following horizon scanning, are close to failing target.

Resolved: The Committee

- Noted the content of the report and the updates given.

8. Monthly Contract and Procurement Report

FP. 16.107 Mr Middlemiss presented this report based on Month 4. It was reported that RAP's remain in place in areas where delivery remains off trajectory. These are updated by the Trust on a monthly basis and are managed through the Contract Review Meetings where areas of concerns are raised.

Mr Middlemiss reported that since this report finance sanctions had been issued as follows; Month 5 - £26,250 and Month 6, £39,250. The year to date total is £188,350. 60% of this is relates to Wolverhampton CCG and 40% to other CCGs.

A query was raised regarding the Action Plan for A&E and whether this addressed the issue of the appropriate use of the Urgent Care Centre. It was noted that this is part of the plan and also that joint triaging had commenced from 1st September.

It was questioned what the consequences are for the Trust if RAPs are not delivered. Clarification was given that sanctions cannot be applied to areas which are part of the Sustainability and Transformation Fund (STF) process. However, part of the performance management process is to ensure action plans are regularly reviewed and updated.

Mr Middlemiss gave an update on the coding and counting issues previously discussed by the Committee pertaining to A&E as follows;

- A mechanism has been put in place to correct the over-charging which has occurred impacting on 2 x A&E HRG's. The Trust has recognised that this has led to over-charging and will refund the difference in activity levels seen prior to the change. The rebate will apply until the issue is resolved (via a system upgrade).

- The second issue regarding potential duplicate patients being seen will also be rectified by an upgrade to the Trust's clinical IT system. Until this occurs, the multiple clinical entries occurring will be corrected and adjusted as part of the reconciliation process.

Mr Middlemiss highlighted a change to the contract negotiation update relating to the Black Country Partnership Foundation Trust. Joint negotiations are proceeding led by Sandwell and West Birmingham CCG, however, Wolverhampton CCG will be retaining a separate contract.

It was reported that a business case from Nuffield Health Limited to extend the current directory of services commissioned to include spinal services, was approved by the Commissioning Committee in September. The level of activity will be adjusted in the Nuffield and RWT contracts as part of the contract negotiation process.

The CCG has identified that Vocare is significantly under plan for activity year to date and will therefore be seeking to claim money back in line with the contract for the Urgent Care Centre. Vocare was advised of this in writing in September and a response is still pending. This will

be followed up at the Contract Review meeting due to be held with them.

Resolved – The Committee:

- noted the contents of the report and actions being taken.

9. Draft Finance Plan 2017/18 – 2020/21

FP.16.108 Mrs Skidmore gave an overview of the latest draft finance plans which have been developed in compliance with the business rules as set out by NHS England, including:

- Identifying a 0.5% contingency which is uncommitted throughout the planning round and remains uncommitted at the point which contracts are agreed
- Holding the required 0.5% risk reserve fully uncommitted (this requirement is for the core allocation only i.e. excluding delegated co-commissioning budgets and running costs)
- Clear non-recurrent utilisation of the remaining 0.5% non-recurrent headroom (where CCGs hold delegated responsibility for GP services they will be required to provide clear non-recurrent utilisation of the full 1% of non-recurrent resources from within the delegated budget).
- CCGs should assume no benefit to the bottom line from the business rule regarding the 0.5% of CQUIN which is being held either by CCGs or Provider organisations as part of the national risk reserve
- Strict adherence to the CCG 2 year allocations that have been issued (subject to changes for HRG4+ and Identification Rules).
- CCGs will be required to confirm adherence to the national must dos (0.56% within each CCG growth uplift).
- CCGs should apply robust inflation and growth assumptions based on historic trends and future plans. Assumptions will be fully tested through the assurance process
- CCGs must meet the national parity requirements around Mental Health and Child and Adolescent Mental Health Services
- CCGs must demonstrate the use of the £3 per head for the GP Forward View

CCGs are also expected to present plans with robust in-year profiling of spend based on activity projections and QIPP delivery.

The Committee considered the high level plan whilst noting that confirmation of CCG allocations is still awaited. Mrs Skidmore reported that delivery of all planning requirements is currently unachievable due to the level of QIPP savings required to meet the business rules however a definite decision cannot be confirmed until allocations are

released as it is likely that allocations will increase. This would reduce the QIPP burden currently modelled.

Mrs Skidmore noted that once the finance plan had been remodelled to include any new allocation, here intention is to share it at the next Finance and Performance Committee with a summary of risks and mitigations. Also included will be a statement on deliverability of the position and a number of options for consideration that would result in a position that is deemed to be reasonable and achievable.

Resolved – The Committee:

- noted the latest position of the draft finance plans.
- will receive an updated plan at the next Finance and Performance Committee in readiness to make recommendations to the December Governing Body meeting regarding the 17/18 budget.

10. Financial Control Environment Assessment (FCE) Improvement Plan

FP.16.109 Mrs Skidmore provided the committee with an update on progress in delivering the FCEA Metrics. Prior to submission to NHS England in September 16, the progress against each standard was reviewed. Mrs Skidmore reported that the CCG was required to provide an action plan for 8 of the 18 metrics in the FCEA. Substantial progress has been made against the 8 metrics since the last update. In the last update the CCG reported achieving 'excellent' on 3 metrics and is now reporting achieving 'excellent in the remaining 5 metrics.

Following the submission to NHS England, feedback is awaited.

Resolved – The Committee:

- noted the contents of the report and the work done to maintain high standards of financial control.

11. Any Other Business

FP.16.110 There were no items raised under any other business.

12. Date and time of next meeting

FP.16.111 Tuesday 29th November 2016 at 12.30pm, 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 4 October 2016
Commencing at 2.00 pm in the PC108, 1st Floor, Creative Industries Centre, Wolverhampton Science Park

MEMBERS ~

Wolverhampton CCG ~

		Present
Pat Roberts	Chair	Yes
Dr David Bush	Governing Body Member / GP	No
Dr Manjit Kainth	Locality Chair / GP	Yes
Dr Salma Reehana	Locality Chair / GP	No
Steven Marshall	Director of Strategy & Transformation	No
Manjeet Garcha	Executive Lead Nurse	Yes

NHS England ~

Alastair McIntyre	Locality Director	Yes
Gill Shelley	Senior Contract Manager (Primary Care)	Yes
Anna Nicholls	Contract Manager (Primary Care)	No
Karen Payten	Senior Finance Manager (Primary Care)	No

Independent Patient Representatives ~

Jenny Spencer	Independent Patient Representative	No
Sarah Gaytten	Independent Patient Representative	No
Peter Price	Vice Chair	No

Non-Voting Observers ~

Ros Jervis	Service Director Public Health and Wellbeing	Yes
Donald McIntosh	Chief Officer – Wolverhampton Healthwatch	Yes
Elizabeth Learoyd	Chief Officer – Wolverhampton Healthwatch	Yes
Dr Gurmit Mahay	Vice Chair – Wolverhampton LMC	No
Jeff Blankley	Chair - Wolverhampton LPC	No

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
Claire Skidmore	Chief Finance and Operating Officer (WCCG)	Yes

Welcome and Introductions

PCC103 Ms Roberts welcomed Elizabeth Learoyd to the meeting in her new role as Chief Officer of Wolverhampton Healthwatch and introductions took place.

Apologies for absence

PCC104 Apologies were submitted on behalf of Karen Payten, Jeff Blankley, Peter Price, Dr David Bush, Trisha Curran, Sarah Southall, Jenny Spencer, Sarah Gaytten, Helen Hibbs and Anna Nicholls.

Declarations of Interest

PCC105 Dr Kainth declared that, as a GP he had a standing interest in all items related to primary care.

As this declaration did not constitute a conflict of interest, Dr Kainth remained in the meeting whilst these items were discussed.

The Committee noted that as Mr McIntyre had not arrived at the meeting it was not quorate at this point.

RESOLVED: That the above is noted.

Minutes of the Meeting Held on 6th September 2016

PCC106 RESOLVED:

That the minutes of the previous meeting held on 6 September 2016 were approved as an accurate record subject to the following amendment:

(PCC189) Primary Care Programme Board Update July 2016 – It was noted that the Atrial Fibrillation proposal had been agreed by the Commissioning Committee not at the QIPP Board meeting.

Matters arising from the minutes

PCC107 There were no matters arising from the minutes.

RESOLVED: That the above is noted**.**

Committee Action Points

PCC108 **Minute Number PCC176 – Premises Charges**
Ms Shelley confirmed that details on the management of transitional funding are to be confirmed and would provide an update at the next meeting.

Minute Number PCC177 – Workforce Strategy
It was noted that this item is on the agenda for discussion.

Minute Number PCC186a – NHS England Update – Primary Care Update
Mr Hastings agreed to contact the Deputy Head of Primary Care at NHS England (NHSE) to share a copy of the final submission with the Committee.

Minute Number PCC186b – NHS England Update – Primary Care Update
Mr Hastings informed the Committee that details on the GP Resilience Programme was included in the Wolverhampton CCG Update on the agenda.

RESOLVED: That the above is noted.

Mr McIntyre joined the meeting.

NHS England Update – Primary Care Update

PCC109 Ms Shelley presented the NHSE update to the Committee outlining the latest developments in primary care nationally and locally. Reference was made to the NHSE GP Resilience Programme (GPRP) which has replaced the Vulnerable Practices Programme. Local teams (DCO) have been asked to confirm practices selections by 18 October 2016 and it was noted that this included practices that have self-referred as well as practices identified by CCGs. Ms Shelley agreed to confirm the number of practices which can be put forward for the Programme for Wolverhampton CCG.

Discussion took place around GPRP in relation to the WCCG Primary Care Workforce Draft Strategy. Ms Garcha stated that there had been difficulty in confirming an NHSE lead for this work and Ms Shelley agreed to confirm details and feedback.

It was noted that there were no General Medical Services (GMS) contract changes this month.

RESOLUTION: That Ms Shelley will confirm the number of Wolverhampton practices that can be put forward for the GPRP programme and also any expressions of interest that they have directly received.

That Ms Shelley will confirm contact details for an NHSE contact in relation to the GPRP / WCCG Primary Care Workforce Draft Strategy work.

NHS England Finance Update

PCC110 Ms Shelley provided an update in Ms Payten's absence and confirmed that there was no change in the month 5 position and therefore a report had not been submitted to the Committee. The Personal Medical Services (PMS) premium has been approved by Mr McIntyre and Emma Cox, Senior Finance Manager (Primary Care), will liaise with Ms Skidmore with regards to the next steps to accessing the funding.

RESOLVED: That the above is noted.

Wolverhampton CCG Update

PCC111 Mr Hastings informed the Committee that the Primary Care Team has now been embedded at the CCG.

New Models of Care
There are currently 5 groups with 90% of practices aligned to Primary Care Home / Vertical Integration models. An event to explore interest in practices joining the Primary Care Home model is taking place this week and will be chaired by Dr Mohindroo and Dr Mahay.

Vertical Integration (VI)
The Royal Wolverhampton NHS Trust (RWT) are in talks with a further Wolverhampton practice in view of them joining the VI programme, which would therefore mean that there will be 4 practices in that model. It was confirmed that the documentation for this would be approved by this Committee.

Mr McIntosh queried what has been done to monitor developing models of care, the benefits to patients and the engagement with regards to new practices joining the process. It was noted that the evaluation process was in the early stages and a set of Key Performance Indicators were being developed. An assurance meeting took place on 3 October 2016 with attendance from NHSE, CCG, RWT and the VI practices. Positive feedback was received from the GPs regarding efficiencies received internally specifically around HR structures and staff training. There is an intention for the assurance meetings to take place on a quarterly basis and the minutes will be shared with the Committee.

GP 5 Year Forward View
There are 83 projects nationally which are being captured in a programme of work. An issue was raised regarding funding and how / when it is made available to CCGs.

Wolverhampton Clinical Commissioning Group (WCCG) Members Meeting
The next WCCG Members Meeting is due to take place on 19 October 2016. The CCG Members Meetings are a key part of our constitutional governance structure and the transition from Joint Commissioning to full delegation will be included as one of the main topics of discussion.

RESOLVED: That the minutes from the VI assurance meeting be shared with the Committee.

Primary Care Programme Board Update

PCC112 Ms Garcha presented an update on the delivery of the work being undertaken by the Primary Care Programme Board. The Committee were informed that the interpreting procurement review of bidders is currently in progress with a new contract commencing in December 2016.

Community Equipment Procurement
Discussion is ongoing with the Local Authority with regards to undertaking a joint procurement following a review of the service specification.

Choose and Book, Advice and Guidance
Discussion has been ongoing with the acute provider with regards to which specialties at the acute provider were not providing this service. The use of Choose and Book was discussed at the September 2016 Clinical Reference Group and it was noted there is a variation of how this service is being used across the City by GPs i.e. telephone or electronic referrals. It was stated that there is a national CQUIN (Commissioning for Quality and Innovation) being introduced from next year which will be used to manage this issue.

RESOLVED: That the above is noted.

Primary Care Operations Management Group Update

PCC113 The Committee was informed of an issue which had been highlighted at a Wolverhampton practice relating to an out of date vaccine being stored in a fridge and staff being unsure of the disposal process.

Ms Roberts queried the level of patient engagement required when a practice was merging / closing, Ms Shelley agreed to confirm and feedback to the Committee.

RESOLVED: That Ms Shelly would confirm the level of patient engagement required when a practice was merging / closing.

Workforce Strategy Update

PCC114 Ms Garcha provided the Committee with an update on primary care workforce analysis and outlined the following documents:

- Draft Wolverhampton CCG Primary Care Workforce Draft Strategy
- Appendix 1 – Primary Care Workforce, Consultation and Scoping report
- Appendix 2 – GP Workforce Data
- Appendix 3 – Workforce numbers mapped with General Practice Models of Care
- Appendix 4 – Workforce Implementation Plan 2016

The Committee noted that the draft Strategy was now out for consultation with members of the Workforce Task and Finish Group until Friday 14 October 2016 for comments.

Ms Shelley queried how the Wolverhampton practices involved in Vertical Integration had been recorded in the analysis. The Meeting also noted that a sense check of the data should be undertaken.

Discussion took place around the authorisation process and it was agreed that the final Strategy should be taken to the Workforce Task and Finish Group on 3 November 2016, the Primary Care Health Strategy Implementation Programme Board on 17 November 2016 and the Wolverhampton CCG Governing Body Meeting on 13 December 2016.

RESOLVED: That Ms Garcha will confirm how the Wolverhampton practices involved in Vertical Integration had been recorded in the analysis.

Social Prescribing Report – For Information

PCC115 In Mr Marshall's absence, a report outlining a proposal for a 12 month pilot for social prescribing was discussed. Mr McIntosh queried which delivery options had been considered and whether an audit of services had been undertaken. Ms Roberts queried whether there were any other costs for signposted services. Ms Skidmore agreed to feed these comments back to Andrea Smith, Head of Integrated Commissioning – Wolverhampton CCG.

RESOLVED: That Ms Skidmore would feedback Mr McIntosh's queries to Andrea Smith.

Any Other Business

PCC116 There were no others issues raised for discussion.

RESOLVED: That the above is noted.

Date, Time & Venue of Next Committee Meeting

PCC117 Tuesday 1st November 2016 at 2.00pm in Stephenson Room, 1st floor, Technology Centre, Wolverhampton Science Park

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Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Minutes of the Primary Care Strategy Committee
Held on Wednesday 12th October 2016
Commencing at 12.30pm in the CCG Main Meeting Room, Wolverhampton Science Park, Glaisher Drive, Wolverhampton

Present:

Steven Marshall	Director of Strategy and Transformation (Chair)
Sarah Southall	Head of Primary Care, Wolverhampton CCG
Jane Woolley	PMO Lead, Wolverhampton CCG
Claire Skidmore	Chief Financial Operating Officer, Wolverhampton CCG
Dr S Reehana	Locality Lead, Wolverhampton CCG
Dr M Kainth	Locality Lead, Wolverhampton CCG
Mike Hastings	Associate Director of Operations, Wolverhampton CCG
David Birch	Head of Medicines Optimisation, WCCG
Vic Middlemiss	Head of Contracting and Procurement, Wolverhampton CCG
Ranjit Khular	Primary Care Transformation Manager, WCCG
Barry White	Project Manager – New Models of Care
Laura Russell (minutes)	Primary Care PMO Administrator, Wolverhampton CCG

Declarations of Interest

PCSC20 No declarations of interest were raised.

Apologies for absence

PCSC21 Apologies were submitted on behalf of Trisha Curran, Manjeet Garcha, Dr DeRosa and Dr Mehta.

Minutes and Actions

PCSC22 The minutes of the previous meeting held on 7th September 2016 were approved as an accurate record.

The action log was shared and the following updates provided;

PCSCS11 – Terms of Reference for Approval
Final amendments have been made to the Committee's Terms of Reference and circulated to the Committee on 19th September 2016. **Action Closed.**

PCSC12 – Risk Register
All workforce leads have been reminded to enter risks pertaining to their task and finish group onto Dtaix. **Action closed.**

PCSC13 - Implementation Plan - Reference Number 1.9
The PITS Project Review Group notes were shared with the Committee on the 30th September 2016. **Action closed.**

PCSC14 - Implementation Plan - Reference Number 2.0 (Localities as Commissioners)
Mr Khular has reviewed the Localities as Commissioners implementation plan and ensured it aligns more appropriately with the group's aims and objectives. **Action Closed.**

PCSC15 - Implementation plan - Reference Number 2.23
Mr Khular has reviewed the wording on reference number 2.23 (Improvement in Practice response rates and ratings in NHSE 360 Stakeholder Feedback Member Practice) to make this more meaningful. **Action closed.**

PCSC16 - Implementation plan - Reference Number 3.0 (Workforce Development).
An updated version for Workforce and Development tasks/timescales will has been provided. **Action Closed.**

PCSC17 - Implementation plan - Reference Number 4.0 (Clinical Pharmacist)
The timescales have been completed. **Action closed.**

PCSC18 - Implementation Plan - Reference Number 5.1
The timescale for committee reference 5.1 has been amended to start from October 2016. **Action closed.**

PCSC19 - Implementation Plan - Reference Number 7.5
Mr Hastings confirmed this area of work has commenced. **Action closed.**

PCSC20 – Implementation Plan
Ms Russell has met with all the work stream leads to review all entries and timescales for all the entries on the implementation plan. **Action closed.**

PCSC21 - Task and Finish Group Highlight Report Including Terms of Reference &FG1 – Practice as Providers
All the term of references for each of the Task and Finish Groups have been reviewed and amended to be more reflective of their objectives. **Action closed.**

PCSC22 - T&FG 4 Clinical Pharmacists in Primary Care
Mr Birch has attended each of the Locality Meetings and due to attend the Members Meeting to promote and the benefits of employing a clinical pharmacist within GP practices. **Action is ongoing and will remain open.**

PCSC23 - NHS Confederation Letter
The letter has been sent out and an application has been submitted to NACP for PCH2. **Action closed.**

PCSC24 - STP Update
No queries were raised with Mrs Southall in relation to reports provided at the meeting. **Action Closed.**

RESOLVED: That the above was noted.

Matters Arising

PCSC23 A) Outcomes of Discussions – Report to Governing Body of the Primary Care Strategy Committee
The report was received and noted by the Governing Body on the 11th October 2016.

B) All Task and Finish Groups Term of References
Mrs Southall informed Committee all the Task and Finish Groups Term of References introductions have been amended to define their purpose more clearly. The final term of references were provided to the Committee for comments/approval. The Committee reviewed all Task and Finish Groups term of references and formally agreed as the final versions.

RESOLVED: That the above was noted.

Risk Register

PCSC24 Risk Register Report Datix
Mr Marshall presented the risk register to the Committee and highlighted there are two green (low) risks and one amber (moderate) risk on the register. Mr Marshall asked Mr Birch in relation to the amber risk ID:440 (unattractive employment option for employment of clinical pharmacists by GP practices) whether there is anything further that can be done to reduce this risk, Mr Birch confirmed this risk score is to remain as moderate.

Ms Skidmore queried why risk ID: 381 Infection Prevention Service had been included onto this Committees risk register. It was highlighted the system pulls through the risks depending on how it is assigned on the system. It was agreed Ms Southall would review and suspend this risk from the Committees risk register.

Discussions took place around the management of risks and the appropriate management tools used to record and monitor the risks. It was agreed that all work stream leads need to review risks associated with their program of work and record on to Datix and their risk log, as the Committee were not assured that all risks are being captured.

RESOLUTION:
Ms Southall to review the risk register and request to suspend risk ID: 381from the Committee's risk register.

All Work stream leads to review risks associated with their program of work and record on to Datix and their risk log.

Performance

PCSC25 Implementation Plan

Ms Southall informed the Committee the status rating has changed to be more reflective of a RAG rating system with blue indicating not started, green as completed, amber as in progress and red meaning slippage.

Dr Kainth asked if the tasks and timescales are standalone or if some tasks dependent on other tasks being completed. It was confirmed that some of the tasks will be dependent on others being completed and this has been reflected within the implementation plan timescales. Ms Woolley highlighted the Strategy Committee's implementation plan indicates the high level objectives and the Task and Finish Groups all have their individual implementation plans. These plans outline the objectives and how they will be achieved, ensuring they correspond with the Committees implementation plan. The individual implementation plans will be shared along with the highlight reports to the Committee each month.

Discussions took place regarding reference number 6.12 regarding Aristotle training as to where this sits within the task and finish groups. MH agreed to speak with Ms Russell regarding this task.

RESOLUTION: Mr Hastings to speak with Ms Russell regarding reference number 6.12 regarding Aristotle training.

Task and Finish Groups

PCSC26 A) Task and Finish Group Practices as Providers

Mr Khular provided an update to Committee on the summary of discussions held at the Task and Finish Group on the 13th September 2016. The Group discussed their terms of reference in relation to membership, quoracy and voting. The key actions from the meeting included establishing a forum to take forward the work around the back office functions and the need to update the programme of work (implementation plan).

Mr White informed the Committee a gap analysis has been undertaken to enable the formation, implementation and operation of Primary Care Homes, with the focus being on Primary Care Home. The anticipation this will form the footprint for other Primary Care Home models. Mr White has engaged with other Task and Finish Groups which are key to the new models of care such as the Workforce Development.

The National Associate of Primary Care (NACP) visited Primary Care Home1 (PCH1) on the 5th October 2016. PCH1 presented to NACP upon the progression to date and next steps of the formation, implementation and operation of PCH1. The presentation was well received and the outcomes from the visit will be provided at the next meeting.

B) Task and Finish Group Localities as Commissioners

Mr Khular informed the Committee the group discussed the structure and role of this Task and Finish Group as there is move towards different models of care that no longer fits with the existing geographical Locality Groups.

Mr Hastings queried what will happen with the existing Locality Group meetings. It was confirmed the Locality Groups will continue in their existing form until December 2016, after which they will change to the Primary Care Home Groupings. Mr Hastings highlighted the cost implications to increase from 3 to 5 groups as well as the impact on the Governing Body Structure. It was agreed Mrs Southall to devise a draft proposal for the next Locality Group Meetings for discussion.

RESOLUTION: Ms Southall agreed to devise a draft proposal of future locality group structures to align to Primary Care Home structures to take to the next round of Locality Meetings for discussion.

C) Task and Finish Group Workforce Development

Mr Khular highlighted the main area of discussion at their meeting was around the workforce scoping and planning. The group discussed the draft Primary Care Workforce Strategy and any comments were to be sent to Manjeet Garcha, however no comments have been received. A potential risk has been highlighted in relation to staff retention due to different organisations offering different pay bands for the same/similar roles as other organisations within the same area.

Mr Marshall asked do the group have a vision of what Primary Care Workforce will look like and its reconfiguration would this be Practice by Practice or Primary Care Home models. It was also highlighted there needs to be a phased vision due to the ongoing changes with reconfiguration of services. The Committee requested that the draft strategy should include a vision component of what the Primary Care Workforce would look like in the future.

The Committee queried where the draft strategy had been circulated, as the Committee noted it should be circulated to Primary Care Colleagues for comments once it had been finalised.

Discussions took place regarding the remit of the group and whether their role also included the attraction and retention of workforce for Wolverhampton. It was confirmed that this area of work will be picked up through this group and covered within their implementation plan. Mrs Southall stated there is recruitment fair being planned for March 2016. This is

aimed for all workforce colleagues where the joint working with the Universities will be promoted and training placements/roles will be showcased

RESOLUTION: Mr Khular /Mrs Southall to ask the group their intentions of the how and where the draft strategy will be shared.

Mr Khular/Mrs Southall to feedback the Committee's request of having a forward vision of what the workforce needs will be in the future within the Workforce Strategy.

D) Task and Finish Group Clinical Pharmacists in Primary Care

Mr Birch advised the Committee the Task and Finish Group meeting arranged on the 17th September had been cancelled due to the launch event across the City of the Antimicrobial Stewardship Programme. The next meeting is planned for November, however the Government plans for funding have been delayed from October until December. Mr Birch has contacted the National Lead and there are difficulties around the professional indemnities for Pharmacists. Discussions followed regarding the national funding delays and how this will impact the implementation plan, it was agreed to monitor and review.

Mr Birch informed the Committee they continue to promote the role of clinical pharmacist and the benefits of employing them within GP practices. A GP survey monkey has been set up to assess GP willingness to recruit to this role.

RESOLUTION: Mr Birch and Ms Russell to monitor and review the implementation plan in light of the delays in national funding.

E) Task and Finish Group GP Contract Management

Mr Middlemiss informed the Committee of the summary of discussions held at their meeting on the 14th September 2016. The group discussed the terms of reference and membership for the group and decided to have two GPs sit on the group on a rotational basis.

The role of the group is to focus on contract implications to ensure fully delegated position. There will be a specific meeting at the end of the month to cross reference and review the MOU for the Hub and full delegation with a view this will be presented at the next Governing Body.

There were three risks highlighted at the meeting these were;

- Uncertainty regarding the future support from the Primary Care hub.
- No established mechanism within the CCG for the application for Full Delegation *– Since the meeting the application has now been received.*
- State of readiness for MCP contracts being awarded on 1 April 2017.

F) Estates Development

Mr Hastings informed the Committee the CCG should receive the outcomes of the ETTF bids shortly. They are hopeful the bids will be successful for cohort 1 and 2 they are unsure for cohort 3 (Bilston Urban Village). Mr Hastings provided an overview of work currently being undertaken in Estates. Ms Skidmore stated there needs to be a focus on defining the Estates Strategy which supports the delivery of the Primary Care Strategy.

G) IM&T Business Intelligence

Mr Hastings reported the following feedback from the group;

- A meeting has been held with Black Country Partnership Foundation Trust to start process for the inclusion of Mental Health records within the Shared Care Record plans.
- The rollout plan for patient public Wi-Fi is being work through which will consider the Changes in GP practice including the costs for the project**.**
- The review of the DXS solution has taken place with agreement for a paper to be submitted to the Primary Care Board.

Record of Escalation

PCSC27 There were no items of escalation to report.

RESOLVED: That the above is noted.

GP 5 Year Forward View

PCSC28 A) NHS England GP Forward View Lead Accountabilities

Mrs Southall provided to the Committee the above report which breaks down all the 83 NHS England projects outlining the leads and responsible work stream lead. There has been confusion from NHS England with regards to notifications of when funding for projects has been released. The CCG have requested if the funding could be given directly to the CCG, an outcome of this request is awaited.

B) Training for Reception and Clerical Staff

Ms Southall informed the Committee this is in response to the 5 year forward view in which NHS England have recently assigned £23,000 to the CCG to spend on training for reception staff. The CCG are working with the LMC to agree a mutual plan on how the money will be spent. The plan is likely to comprise of one training place for each practice to attend a face to face learning event provided by a reputable preferred provider who will share their training material. The aim then is for the training material to be cascaded to other reception personnel within practices. This will be overseen by the Practice Managers who will review the effectiveness through the Practice Managers Forum.

STP Update

PCSC29 Mr Marshall informed the Committee the final submission will be the 21st October 2016.

RESOLVED: That the above is noted.

Discussion Items

PCSC30 PMO Process Review

The Primary Care PMO process was presented to the Committee which outlined the role of the PMO and the benefits of applying this methodology to the Primary Care function. The benefits include;

- A central and consistent approach across the CCG
- Improvement in the visibility and awareness of the Task and Finish Groups
- Ensuring that the CCG meets its Corporate Governance Requirements
- To help monitor and track the delivery of the milestones in the Task and Finish Groups
- To save time when reporting information to the Committees
- To assist with planning and prioritisation of milestones

The Committee was informed of the programme delivery and assurance process including the documents which will be used to support the management and monitor the delivery of the Primary Care work. It was agreed that Ms Woolley and Ms Russell would be meet with the work stream leads to start plotting the monthly progression documentation.

RESOLUTION: Ms Woolley and Ms Russell to meet with the work stream leads to plot the monthly progression/assurance updates.

Any Other Business

PCSC31 There were no further items for discussion.

RESOLVED: That the above is noted.

Date of next meeting

Thursday 17th November 2016 at 1.00pm – 3.00pm in the CCG Main Meeting Room, Wolverhampton Science Park

NHS
Wolverhampton
Clinical Commissioning Group

Wolverhampton Clinical Commissioning Group
Audit and Governance Committee

Minutes of the meeting held on 19 July 2016 commencing at 11.00am
In Main Meeting Room, Science Park, Wolverhampton

Attendees:

Members:

Mr J Oatridge	Chairman
Mr P Price	Independent Lay Member
Mr L Trigg	Independent Lay Member

In Regular Attendance:

Ms D Kortus	Manager, Counter Fraud Specialist, PwC
Mr P McKenzie	Corporate Operations Manager, WCCG
Mr H Rohimun	Executive Director, E&Y LLP
Mrs C Skidmore	Chief Finance and Operating Officer, WCCG
Mr M Surridge	Senior Manager, E&Y LLP
Mrs J Watson	Senior Internal Audit Manager, PwC (part meeting)

In Attendance

Mr S Grayson	Local Security Management Specialist, CWADIT (part meeting)
Mrs M Tongue	Head of Financial Resources, WCCG (part meeting)
Miss M Patel	Administrative Support Officer, WCCG (minute taker)

Apologies for attendance:
AGC/16/60 Apologies for absence were submitted by Ms A Breadan.

Declarations of Interest
AGC/16/61 Mr Trigg declared an interest in Agenda Item 13 and advised that he would withdraw from the meeting when discussions take place around Committee membership.

Minutes of the last meeting held on 24 May 2016
AGC/16/62 The minutes of the last meeting were agreed as a correct record.

Matters arising (not on resolution log)
AGC/16/63 The following was raised;

- AGC/16/55 –2015/16 Report to those charged with Governance (ISA260) Mrs Skidmore asked that the in the paragraph 'Mrs

Skidmore described to the Committee how the ledger system can post entries into SOFT codes that whilst not complying with a 'gross accounting' principle were not necessarily incorrect.' that the word 'SOFT' was amended to 'SOFP'.

RESOLUTION: That Miss Patel would amend this correction in the final minutes.

Resolution Log

AGC/16/64 The resolution log was discussed as follows;

- Item 69 (AGC/16/15) – EY to share with Committee how much reliance is place on 3rd party/service auditor reporting and include in report – feedback had been received and this action could be closed.
- Item 70 (AGC/16/16) – Committee to consider a Deep Dive from the Risk Register on a quarterly basis – this action was to remain open on the register.
- Item 75 (AGC/16/36) – Benchmarking of Risk Management against that of other CCGs – a workshop had been set up in September 2016. Ms Watson will draw upon examples from other organisations in the presentation.
- Item 76 (AGC/16/36) – Local Counter Fraud Staff Survey to be shared with Committee when finalised – this was covered on the agenda and could be closed.
- Item 78 (AGC/16/36) - Conflicts of Interest. Following consultation a CCG response had been submitted to NHS England – new guidance had been received and had been taken to the Governing Body, this is covered later on the agenda.
- Item 80 (AGC/16/40) – Entry to be added to CCG risk register to reflect the mitigated risk of journals into the ledger not being fully authorised – this had been added to the register and this item could be closed.
- Item 82 (AGC/16/32 & AGC/16/52) – Tier 4 CAMHS (risk ID 267) – continued red risk for CCG. Waiting confirmation from NHS England that this has been entered on their risk register before risk is closed down by CCG – email had been received from NHS England. As this still remained open on the CCG risk register at the date of the meeting this action was to remain open.

RESOLUTION: Resolution log to be updated accordingly.

Chief Internal Auditors Progress Report

AGC/16/65 Mrs Watson presented this report which gave an update of progress with Internal audit work including summaries of the key outcomes of Internal Audit assignments finalised and reported since the last meeting.

- Item 1 – Corporate Governance – looking at how the CCG develops its strategy and how it is embedded in the organisation.
- Item 2 – Risk Management – a review will be undertaken of risk management arrangements and a meeting has been arranged with Manjeet Garcha – Executive Director of Nursing and Quality.

- Item 3 – Finance - a review of financial controls operated by the CCG on a rotation basis.
- Item 4 – IT Risk Diagnostic – Meeting had been arranged with the CCG and RWT. CCG IT arrangements would be looked at.
  Item 5 – Audit follow-up – An update was given on outstanding audit actions as of the 18 July 2016. They were rated as being 3 Low Priority, 25 Medium Priority and 2 High Priority. The actions rated high were being looked at and had plans of action.
- Item 6 – Contract Management – the intention is to look at how the CCG links finance activity and quality consistently across all contracts.
- Item 7 – Stakeholder Engagement – a review to be under taken to look how the CG works with its stakeholders, both on an external and internal basis.

  In reference to Ref 24 'The CCG should undertake a thorough review and update of its business continuity framework, critical systems, assessments and operational documentation.' Mrs Skidmore advised that there was ongoing work around this. Mr Oatridge felt that the slippage in delivery timescales was a concern.
  Mrs Skidmore suggested that progress reports could be shared and would ask Mr A Smith, Emergency Planning Manager to produce a report for the Governing Body. This would also be picked up through the Operations Board by Mrs Skidmore.

RESOLUTION: The Committee;

- The group noted the contents and comments of the report.
- Noted that reports will be produced for Governing Body and picked up thorough Operations Board.

Internal Audit Charter

AGC/16/66 Mrs Watson presented the Internal Audit Charter to the Committee, which is a requirement of the Public Sector Internal Audit Standards (PSIAS).

Mr Oatridge felt that it would be beneficial for the Head of Internal Audit Ms Breadon to attend future Committee meetings.

RESOLUTION: The Committee:

- Noted the contents and comments relating to this report.

Ms Watson left the meeting.

Counter Fraud Progress Report

AGC/16/67 Ms Kortus introduced the paper which highlighted the progress on counter fraud activity at the CCG against the Annual Local Counter

Fraud Work Plan. The plan had been approved at the Committee on 19 April 2016.

The key points were highlighted as follows;

- Inform and Involve – including Team introduction and Fraud awareness.
- Prevent and Deter – Fraud Risk Group and Fraud Risk Assessment and Fraud Alerts.
- Hold to account – Strategic Governance covering Anti-Fraud Standards and Other Strategic Governance Activity.

RESOLUTION: The Committee agreed to note this report.

Local Security Management Annual Workplan

AGC/16/68 Mr Grayson presented the report to inform the Committee of the proposed plan of work in relation to Security Management.

It set out actions required to meet the security standards of NHS Protect. Key areas outlined with summaries were Strategic Governance, Inform and Involve, Prevent and Deter and Hold to Account.

Mr Price asked Mr Grayson if the remit of this work was just around the CCG or if it also covered practices. Mr Grayson advised that alerts would be sent to practices when deemed necessary. Workload may increase once the CCG becomes fully delegated for Primary Care Community Commissioning

RESOLUTION: The Committee accepted the report and agreed to receive future updates on progress of the workplan.

Mr Grayson left the meeting

Annual Audit Letter including Horizon Scan – upcoming issues in the audit landscape

AGC/16/69 Mr Surridge and Mr Rohimun presented the Annual Audit Letter. Following the completion of their procedures for the year ended 31 March 2016.

RESOLUTION: The Committee noted and received the report.

Risk Register Reporting/Board Assurance Framework

AGC/16/70 The Quality Team were unable to attend the Committee meeting to present this report.

Mr Oatridge noted that the document received for this agenda item was substantial, however did not offer sufficient clarity to the meeting. Mr Oatridge informed the group that he would address this with Mrs M Garcha, Executive Director of Nursing and Quality.

Mr Surridge felt that whilst assurance was received, it is difficult to extract the key headlines from all of the detail. Mrs Skidmore reiterated that the purpose of the Committee was to receive assurance around the robustness of the CCG's risk process but not to analyse the detail of the content at this Committee.

In relation to page 174 of the presentation within this item an omitted word was noted as follows 'Detail will be excluded from **public** reports to Committee's and groups to maintain confidentiality/sensitivity of content'. Mrs Skidmore agreed to feed this back to Mrs Garcha.

RESOLUTION: The Committee did not receive assurance from this document.

- That this item was added to the agenda for the next Committee meeting and attendance from a member of the Quality Team.
- Mr Oatridge to speak to Mrs Garcha regarding points raised about the paper.
- Mrs Skidmore to feed back comments on presentation to Mrs Garcha.

Review of Performance against Whistleblowing Policy

AGC/16/71 The HR63 Whistleblowing Policy was presented to the Committee by Mr McKenzie. The purpose of the report was to provide the Committee with details of the operation of the CCG's whistleblowing policy to allow the Committee to monitor its effectiveness.

There have been no disclosures received at the CCG regarding whistleblowing in the last 12 months.

The policy had been subject to some minor amendments (around contact details). It had also been subject to a 'policy health check' before the change of provider by HR and the CSU.

There is now a specific guidance around conflict of interests.

Mr Oatridge enquired if the Policy should apply to Governing Body Members. Mr McKenzie advised that it would apply in principle but they would not be able to receive the same legal protection received by staff. Mrs Skidmore suggested getting a statement from HR to clarify this.

RESOLUTION: The Committee:

- Received this policy and received assurance from it.
- Asked for from HR regarding applicability of the policy to Governing Body Members.

New Conflict of Interest Guidance

AGC/16/72 Mr McKenzie presented the Policy on Declaring and Managing Interests Including Managing Conflicts of Interest. The Committee was asked to review the revisions to the policy following publication of revised national guidance and to consider the implications for membership of this Committee.

Mr Trigg had declared an interest in this item and would only remain for the part related to discussion around the actual policy.

A final version of the new statutory guidance on managing conflicts of interests was published on 30 June 2016.

A revised version of the CCG's Policy on Managing Interests was presented to the Governing Body at the Governing Body Meeting on the 12 July 2016 for approval pending consideration by other stakeholders. The Committee were asked for views as part of the further review.

RESOLUTION: The Committee;

- Supported and agreed the revised policy for declaring and managing interests.

Discussion on the Committee membership was deferred to the end of the meeting.

Mrs Tongue joined the meeting.

Assurance of the Robustness of Activity and Performance Monitoring

AGC/16/73 Mrs Skidmore provided assurance to the Committee that CCG activity and performance monitoring processes are proactive and robust and sought endorsement for a work programme to audit coding practice at RWT in order that the CCG can be satisfied with current system and process.

RESOLUTION: The Committee received and noted the this report and approved the recommendation.

Losses and Compensation Payments – Quarter 1 2016/17

AGC/16/74 Mrs Skidmore presented this report and advised the Committee that there had been no losses or special payments for the period ending 30 June 2016.

RESOLUTION: The Committee received and noted the report.

Suspension, Waiver and Breaches of SO/PFPS

AGC/16/75 Mrs Skidmore noted that there have been no suspensions of SO/PFPs in quarter 1 2016/17.

2 waivers were raised during quarter 1.

A query was raised around 2 retrospective orders in quarter 1 relating to performance. Details to be checked and clarified to the Committee.

RESOLUTION: The Committee;

- Noted the contents of the report.
- Agreed to receive an update regarding the figure for performance relating to the analysis of retrospective orders in quarter 1 2016/17 (£12,667).

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

AGC/16/76 The Committee noted that as at 30 June 2016 there were:

- 3 sales invoices greater than 10k and over 6 months old.
- 14 purchase ledger invoices greater than £10k and over 6 months old. Noted that 5 invoices will be paid in July.

RESOLUTION: The Committee received this report and received assurance from it.

Review of Prime Financial Policies (PFP)

AGC/16/77 Members were asked to review the amendments to Prime Financial Policies, Scheme of Reservation and Detailed Scheme of Delegation prior to them being submitted to the governing body for approval.

RESOLUTION: The Committee noted the amendments in the report and supported an action to take the final version to the Governing Body for approval as part of the broader changes to the constitution that will be required as part of the application for delegated primary care commissioning.

Mr Trigg left the meeting

New Conflict of Interest Guidance

AGC/16/78 Under Point 3 of the guidance – Lay Member Recruitment, there was a strong recommendation that CCGs should appoint a role for an additional lay member to serve on the Governing Body for Finance and Performance. Mr Price had expressed an interest in this role and the Governing Body supported this appointment to the post. Mr Price will take up his duties in shadow form pending this being formalised through the CCG's constitution late in the year.

This would create a vacancy on this Committee for an independent member. Also, given the expansion of the Committee's responsibilities, it was suggested that a new role of Deputy Chair is created. The Remuneration Committee have been asked to formally approve this new role and agreed that Mr Trigg should be appointed to this position.

RESOLUTION: The Committee;

- Noted the appointment of Mr Price as Lay Member for Finance and Performance Committee.
- Noted Mr Trigg's appointment to the new role of Deputy Chairman of the Audit and Governance Committee subject to approval by the Remuneration Committee.
- Agreed that the vacant position on the Audit and Governance Committee should be recruited to appropriately.

Any Other Business

AGC/16/79 There were no items to discuss under this agenda item.

Date and time of next meeting

AGC/16/80 Tuesday 15 November 2016 at 11.00am in the CCG Main Meeting Room, Science Park

Signed:

Dated:

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

Minutes - 19 October 2016

Attendance

Members of the Health and Wellbeing Board

Councillor Val Gibson	City of Wolverhampton Council
Ros Jervis	Service Director - Public Health and Wellbeing
Councillor Roger Lawrence	Chair - City of Wolverhampton Council
Councillor Paul Sweet	City of Wolverhampton Council
Linda Sanders,	Strategic Director, People
David Loughton	Chief Executive The Royal Wolverhampton Hospital NHS Trust
Jeremy Vanes	Chairman The Royal Wolverhampton Hospital NHS Trust
Donald McIntosh	Healthwatch Wolverhampton
Robin Morrison	Healthwatch Wolverhampton
Alan Coe	Independent Chair Wolverhampton Safeguarding Boards
Steven Cartwright	Business Change Manager

Employees

Paul Smith	Interim Manager for Commissioning Older People
Earl Piggott-Smith	Scrutiny Officer
Steven Cartwright	Programme Manager, Transforming Adult Social Care

In attendance

Sara Fellows	NHS Wolverhampton CCG
Andrea Smith	NHS Wolverhampton CCG
Karen Evans	NHS Wolverhampton CCG
Tracey Cotterill	BCPFT
Chief Inspector Tracey Packham	West Midlands Police
Paul Smith	Head of Commissioning - Older People

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies for absence (if any)**

Apologies were received from the following members of the Board:

- Councillor Sandra Samuels
- Councillor Paul Singh
- Chief Superintendent Jayne Meir
- Tracy Taylor – Chief Executive - Black Country Partnership NHS Foundation Trust
- Dr Alexandra Hopkins – University of Wolverhampton

2 **Notification of substitute members (if any)**
Tracey Cotterill attended the meeting on behalf of Tracy Taylor – Black Country Partnerships Foundation Trust

Chief Superintendent Jayne Meir attended the meeting on behalf of Chief Inspector Tracey Packham

3 **Declarations of interest (if any)**
There were no declarations of interest.

4 **Minutes of the previous meeting**
That the minutes of the meeting held on 20 July 2016 be confirmed as a correct record and signed by the Chair.

5 **Matters arising**
There were no matters arising from the minutes.

6 **Summary of outstanding matters**
Resolved:

The summary of outstanding minutes was noted.

7 **Health and Wellbeing Board Forward Plan 2016/17**
Ros Jervis, Service Director Public Health and Wellbeing, introduced the report and explained that the new layout is an initial proposal to make the agenda planning process more inclusive and dynamic. The new form will include a short summary about each agenda item. The changes are intended to set out a rolling programme of issues that will be discussed by the Board. The plan will be updated at each meeting.

The Service Director encouraged representatives of partner organisations to submit items for the agenda. The Board were invited to comment on the draft forward plan.

The Board supported the proposed changes to the forward plan and welcomed the opportunity to submit agenda items.

Alan Coe, Wolverhampton Safeguarding Board, suggested that the annual reports for the Adult Safeguarding and Children's Safeguarding Boards should be added to the agenda for meeting on 30 November 2016.

Resolved

1. The Board agreed to merge the summary of outstanding matters into the new forward plan format for future meetings.
2. The annual Safeguarding Board reports to be presented to the Board on 30 November 2016 for consideration.

8 **Child and Adolescent Mental Health Services (CAMHS) Local Transformation Plan**
Sarah Fellows, Mental Health Commissioning Manager, Wolverhampton Clinical Commissioning Group, presented the report on behalf of Fred Gravestock who was unable to attend the meeting.

The Mental Health Commissioning Manager explained that the organisation is required to refresh its Wolverhampton Children & Young People's Mental Health and Wellbeing Local Transformation Plan and present it to the Board for sign off.

The Mental Health Commissioning Manager gave an overview of the vision in the plan to provide young people and children in Wolverhampton with access to timely, integrated and high quality mental health services that are accessible and responsive to their needs.

The Mental Health Commissioning Manager commented on the importance of delivering services that can respond to the growing need and increased demand upon the whole health service. The strategy is proposing to transform the delivery of the CAMHS service. The CCG is working with NHS England to deliver a more responsive service across Wolverhampton.

The Board were invited to comment on the plan. The Board made reference to other initiatives such as HeadStart which is aimed at improving the emotional health and wellbeing of children and young people and the link to the plan.

The panel requested an update on the Children's Outcomes Framework (Appendix A) so that it covers the same period as the GANTT chart (Appendix F) so that the Board can reach a more informed view about the plans for the service. The Mental Health Commissioning Manager agreed to bring a refreshed GANTT chart to a future meeting of the Board.

The Board discussed the reference in the document to tier 1 and 2 and stated aim in the same document to implement a tier-less whole system across health, education and social care. The Board suggested that the document needs to be more consistent and the language used needs to reflect the clear focus on partnership working. The Board suggested an alternative description of the service is needed.

The Mental Health Commissioning Manager accepted the continued use of Tier 1 and Tier 2 was confusing and the issue had already been highlighted in discussions with colleagues. The situation is complicated by the funding process used by NHS England which uses these terms to describe the level of services available. The Mental Health Commissioning Manager agreed to discuss this further with colleagues and report the outcome to a future meeting of the Board. The Mental Health Commissioning Manager advised the Board that a submission for funding has been submitted to NHS England.

The Board queried how the plan will better meet the needs of adult black males who are over represented in terms of accessing mental services, but much lower numbers are reported as accessing these services aimed at children and young people. The Mental Health Commissioning Manager accepted that there is an over representation of older male men in the service. This issue is a priority issue for the service and work is being with BCPFT to look at what the current provision is and how it is meeting the needs of black and minority groups. The review will also consider meeting the mental health needs of new arrivals to the City.

The Board queried the reference in the plan to the role of GPs and willingness to engage with other agencies in identifying young people who may need to be referred to appropiate wellbeing services. The Board discussed the recent findings of Children's Commissioner report detailing the poor experiences of users across England wanting to access mental health services.

The panel discussed the wider impact on the individual and society of not identifying and supporting young people, in particular vulnerable children, who need to be appropriately referred.

Resolved:

The Board agreed to sign-off the refresh of the Wolverhampton Children & Young People's Mental Health and Wellbeing Local Transformation Plan.

9 **Wolverhampton Integrated End of Life Care Strategy**

Karen Evans, Solutions and Development Manager (Wolverhampton CCG) introduced the report and explained that the report details the progress in developing an integrated strategy for end of life care. The strategy provides a whole pathway approach to end of life care. The Board were asked to consider and formally approve the final version of the strategy. The Solutions and Development Manager commented that the strategy puts the patient at the centre and ensures services are responsive and can support the needs and choices of patients and those closest to them.

The Solutions and Development Manager commented that the strategy has been informed by national guidance and also a recognition that the Strategy seeks to ensure that professionals and services deliver the best possible person centred care and support to people as they approach the end of life.

The Solutions and Development Manager outlined the vision for the new End of Life service and confirmed that the Strategy was co-produced with all partners to ensure support for the integrated strategy.

The Board discussed the importance of people having a choice about their care arrangements and being involved in key decisions. The Board supported the view that the strategy should take account of the wishes of the patient.

The Board discussed the challenges of people do not have the capacity to make informed decisions about their end of life care arrangements and the need for appropiate safeguarding arrangements. The issue of people dying in care homes and the need to ensure that plans are followed. The Board commented that Staffordshire have produced some interesting work in end of life which could be shared with members.

The Board discussed the statistics on the place of death – when compared to the England average the rate of Wolverhampton is higher than average in all categories of deaths in hospital. The rates for people that choose to die either in their own home or care home is lower in Wolverhampton when compared to the England average. The findings suggest that most people would prefer to die in their own home rather than in a clinical setting. The Board discussed the validity of the measure and extent to which people feel enough confident to make a choice.

Resolved:

The Board agreed to endorse the Wolverhampton Integrated End of Life Care Strategy.

10 **Workshop "Living Well, Feeling Safe"**

Linda Sanders, Strategic Director – People, outlined a proposal to host an event to raise the profile of the work of HWBB. The suggested date for the event is February 2017 and that it should involving community and voluntary groups in the steering group. The Board suggested that the event could be linked to Residents Week – this event is planned for March 2017 and how it can be supported. The Board discussed possible topics that could be included. The Board supported the idea that wellbeing could be a theme of the event.

Resolved:

1. The Board endorsed the idea of hosting a “Living Well, Feeling Safe” event in Wolverhampton during 2017.

2. Members of the Board were invited to either share their ideas for the event or to volunteer to be part of the working group.

11 **Wolverhampton CCG Commissioning Intentions 2017/18-2018/19**

Steven Marshall, Director of Strategy and Transformation, introduced the report. The report provides an update on progress across a range of health activities. The Director of Strategy and Transformation advised the Board that the CCG will become responsible for commissioning primary and medical services from 1.4.2017. The Director of Strategy and Transformation advised that it will take time to deliver programme of work detailed in the roadmaps.

The Board were invited to endorse the commissioning intentions of the CCG detailed in the report.

The Board queried the opportunities for the public to be involved in the developing and shaping the commissioning of services. The Director of Strategy and Transformation advised that the development of the strategy has involved public consultation in developing new models of care. The aim of the changes is to achieve the best outcome for patients.

Resolved:

The Board agreed to endorse the commissioning intentions of the CCG as detailed in the report.

12 **Primary Care Strategy - update**

Steven Marshall, Director of Strategy and Transformation, introduced the report and explained that this report is an update on progress. The Director of Strategy advised the Board about the programme about the list of activities aimed at delivering the Primary Care Strategy.

The Board commented on the level of fees charged by GPs for the provision of preventative and enhanced services and queried whether the planned changes will give the CCG greater control over this area. The Director of Strategy and Transformation commented that as GPs are independent contractors the issue of the fees will need to be negotiated as part of a future discussion about commissioning intentions.

The Director of Strategy advised the Board that Wolverhampton CCG is currently in the process of completing an application to NHS England for fully delegated responsibilities for the commissioning of primary medical services from 1 April 2017.

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

Resolved:

The Board welcomed the report and noted the progress towards the implementation of the CCG Primary Care Strategy.

13 **Better Care Fund (BCF) update**

Paul Smith, Acting Head of People Commissioning, introduced the report and gave a summary of the progress made towards the delivery of the 2016/17 programme plan. The Acting Head of People Commissioning advised the Board that the rapid intervention teams had expanded from a Monday to Friday service to a seven day service to help prevent emergency admission.

The Acting Head of People Commissioning gave examples of recent work streams aimed at improving the patient experience funded by the BCF programme. For example, the dementia care work stream and the Memory Matters pilot. The project was launched in July 2016 and is based in Wednesfield Library. The Acting Head of People Commissioning advised that there are discussions about offering the service in other areas. The aim is have three co-located teams supporting this project. The Board welcomed the plans for the co-location of services. The Board queried the criteria that would be used to determine the sites and wanted an assurance that service users and carers will be involved in the decision. Linda Sanders confirmed that the public would be consulted about the location of sites.

Linda Sanders commented that the City of Wolverhampton Council had been nominated to be named Dementia Friendly Organisation of the Year at this year's Alzheimer's Society Dementia Friendly Awards.

The Board queried the rationale for using the system Graphnet as the Black Country standard in the medium term to support the sharing of data across the health and social care system, while planning to introduce the Fibonacci system locally, which is due to go live in December 2016. The Board were reassured of the plans to introduce a system can that can provide professionals with real time access to patient and social care records.

Resolved:

The Board welcomed the report and noted the progress towards the delivery of the 2016/17 programme plan.

14 **Public Health Lifestyle Survey 2016**

Ros Jervis, Service Director for Public Health and Wellbeing, introduced the report and outlined the key findings of the Wolverhampton Healthy Lifestyle Survey. The Service Director advised the Board of the methodology used to collect the survey data. The survey was based on interviews with 9000 residents and checks were done to ensure that the sample was representative of the demographic profile of the city.

The aim of the survey was to identify the level of lifestyle risk factors across the city and to provide better local intelligence. The Service Director advised the Board of the key headlines and the work done to map the impact of multiple risk health factors.

The information will be used to determine how resources will be targeted in the future.

The Board queried the methodology used to identify residents who took part in the doorstep survey and if the timing of visits would exclude some groups. The Service Director reassured the Board that the importance of getting a representative profile was part of the brief given to M-E-L Research, who were commissioned to conduct the survey.

Resolved:

The Board welcomed the report and supported the use of the survey findings to inform the planning and delivery of healthy lifestyle services for the City.

15 **Care Act 2014 Implementation: Stocktake Six Submission Summary - report to follow**

Steven Cartwright, Programme Manager, advised the Board that there has been a requirement as part of the implementation of the Care Act 2014 for all local authorities to submit a regular stocktake of progress in meeting its responsibilities. The Programme Manager gave a summary of Wolverhampton's sixth and final stocktake submission to the Local Government Association (LGA), noting the work undertaken to implement and embed the Care Act reforms in Wolverhampton.

The Board discussed the reference to care given to prisoners detailed in the summary findings and queried the low number of care and support assessments.

Resolved:

The Board welcomed the good progress and the positive comments by the LGA about the performance of the Council in meeting its responsibilities as detailed in the Care Act 2014.

16 **Exclusion of press and public**

To pass the following resolution:

That in accordance with Section 100A (4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business as it involves the likely disclosure of exempt information falling within paragraph 3 of Schedule 12A to the Act relating to the business affairs of particular persons.

17 **Sustainability and Transformation Plans (STP) 2016/17 - 2020/2021**

Steven Marshall, Director of Strategy and Transformation, gave a brief update on progress in developing the plan. The plan will be submitted to NHS England on 21 October 2016. The Board discussed the implications of the plan and the level of public consultation.

Resolved:

The Board noted the progress and agreed to receive a further update report at a future meeting.

The meeting closed at 14:25

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