NHS
Wolverhampton
Clinical Commissioning Group

A meeting of the Wolverhampton Clinical Commissioning Group Governing Body will take place on Tuesday 11th April 2017 commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

A G E N D A

		1	Declarations of Interest		
		2	Minutes of the meeting of the Wolverhampton Clinical Commissioning Group Governing Body meeting held on 14 March 2017		1 - 10
		3	Matters arising from the minutes		
		4	Committee Action Points		11 - 12
		5	Apologies for absence		
		6	Chief Officer Report	Dr H Hibbs	13 - 18
		7	Black Country Sustainability Transformation Plan	Dr H Hibbs/Mr S Marshall	19 - 24
		8	Future Commissioning across the Black Country	Dr H Hibbs/Mr S Marshall	
		9	Audit and Governance Interim Chairing Arrangements	Mr P McKenzie	25 - 30
		10	Better Care Fund Plan	Ms C SkidmoreMr S Marshall	31 - 70
			Committee Reports		
		11	Commissioning Committee	Dr J Morgans	71 - 74
		12	Quality and Safety Committee	Dr R Rajcholan	75 - 102
		13	Finance and Performance Committee	Ms C Skidmore	103 - 126
		14	Remuneration Committee	Mr J Oatridge	127 - 132
		15	Primary Care Joint Commissioning Committee	Ms P Roberts	133 - 136

		16	Primary Care Strategy Committee	Mr S Marshall	137 - 146
		17	Communication and Engagement update	Ms P Roberts	147 - 152
			Items for Information		
		18	Minutes of the Quality and Safety Committee		153 - 164
		19	Minutes of the Commissioning Committee		165 - 170
		20	Minutes of the Finance and Performance Committee		171 - 180
		21	Minutes of the Primary Care Joint Commissioning Committee		181 - 186
		22	Minutes of the Primary Care Strategy Committee		187 - 196
		23	Health and Wellbeing Board minutes		197 - 204
		24	Any Other Business		
		25	Members of the Public/Press to address any questions to the Governing Body		
			Date and time of next meeting ~ Tuesday 9 May 2017 – Governing Body Board Meeting		

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Minutes of the Governing Body Meeting held on Tuesday 14 March 2017
Commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

VOTING MEMBERS ~

Clinical ~		**Present**
Dr D De Rosa ~ Chair	Board Member	Yes
Dr D Bush	Board Member	Yes
Dr M Kainth	Board Member	Yes
Dr J Morgans	Board Member	Yes
Dr R Rajcholan	Board Member	No
Management ~		
Ms M Garcha	Executive Lead for Nursing and Quality	Yes
Dr H Hibbs	Chief Officer	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	No
Ms P Roberts	Lay Member	No
Ms H Ryan	Lay Member	Yes

In Attendance ~

Ms H Cook (part)	Communications and Engagement Manager
Ms W Ewins	Wolverhampton Council
Ms K Garbutt	Administrative Officer
Mr M Hastings	Associate Director of Operations
Mr D Hughes (part)	Sandwell Clinical Commissioning Group
Mr R Jervis	Public Health Director
Ms E Learoyd	Health Watch representative
Mr P McKenzie	Corporate Operations Manager
Ms C Parker (part)	Sandwell Clinical Commissioning Group
Mr D Watts	Wolverhampton Council

Apologies for absence

Apologies were received from Dr R Rajcholan, Mr P Price, Ms P Roberts

Declarations of Interest

WCCG.1736 Dr D De Rosa declared an interest as currently his practice have signed the necessary papers to support vertical integration with his practice and the Royal Wolverhampton Trust with a view to GMS services being sub-contracted to the Trust as part of the vertical integration project. There was not a conflict between this interest and any of the items on the agenda so Dr De Rosa remained in the Chair throughout the meeting.

Dr J Morgans declared an interest as he is currently working as a locum on an agency basis. This is at a practice who are currently part of the vertical integration project which is on an ad hoc basis.

Mr J Oatridge declared an interest in agenda item 7 - Chairing Arrangements.

RESOLVED: That the above is noted.

Dr Kainth arrived

Demand Management

WCCG.1737 A video was played "The play your care right games show". Ms H Cook reported this is to encourage people to access the correct services. It will be part of a social media campaign and confirmed this can be uploaded onto screens within GP practices.

Minutes

WCCG.1738 **In Attendance ~**

Ms R Jervis reported she did not attend the meeting on the 14 February 2017 as stated in the minutes.

WCCG.1711 Primary Care Joint Commissioning Committee

Ms Garcha pointed out the first sentence should read "Ms M Garcha…"

RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group Governing Body meeting held on the 14 February 2017 be approved as a correct record subject to the above amendments.

Matters arising from the Minutes

WCCG.1739 There were no matters arising from the minutes.

RESOLVED: That the above is noted

Committee Action Points

WCCG.1740 RESOLVED: That the progress report against actions requested at previous Board meetings be noted.

Chief Officer Report

WCCG.1741 Dr H Hibbs presented the report. She highlighted Pharmacies in the City have confirmed their willingness to train their staff as Health Champions. This is part of the Healthy Living Pharmacy Scheme; training commenced in February and has been met with high levels of uptake for not only Pharmacy champions but also leadership training too.

Following a review in 2014/15 of the local Musculoskeletal (MSK) services Wolverhampton Clinical Commissioning Group (WCCG) agreed to procure a Community Integrated MSK Service. The new service is expected to go live from 1 April 2017.

Dr Hibbs reported that Dudley and Walsall Mental Health Partnership NHS Trust have agreed to receive a business case from Black Country Partnership Foundation Trust and Birmingham Community Healthcare NHS Foundation Trust with regards to a proposed merger. The full business case is planned to be submitted in October 2017.

Discussions at the City Board were held around making Wolverhampton a sustainable city and it was agreed to focus on how Wolverhampton can become a 'smart city'.

With regard to the new MSK service Dr D Bush raised what the communication will be to GPs regarding pathways. Ms C Skidmore confirmed this is currently being actioned.

RESOLVED: That the above is noted.

Chairing Arrangements

WCCG.1742 Dr D De Rosa referred to the tabled report Interim Chairing Arrangements. It was agreed by the Governing Body that Mr Oatridge remain for this agenda item.

Mr P McKenzie stated that this is to recommend to the Governing Body a proposal to put in place an interim chair for six months following the resignation of the current Chair with effect from 1 April 2017.

Dr Reehana arrived

Mr McKenzie gave an overview of the report highlighting the appointment procedure. Clinical Commissioning Group's (CCG's) constitution does not have explicit provisions governing the appointment of an Interim Chair. Standing Orders set out the procedure for the appointment of a substantive chair, which is an election amongst the elected GP members. Dr Hibbs emphasised the importance of stability whilst there is such a lot of change going on externally. Dr De Rosa supported the proposal of Mr Oatridge as Interim Chair with his extensive experience and knowledge. Mr McKenzie confirmed there is a job description in place. At the Members Meeting in April 2017 the options regarding the future structure of the Governing Body will be discussed. Mr McKenzie confirmed work is underway and outline suggestions are in place.

RESOLVED:

(1) That the Governing Body agreed to appoint Mr Jim Oatridge as Interim Chair of the Governing Body for a six month period commencing 1 April 2017.
(2) That the Governing Body agreed to co-opt Dr Salma Reehana as Interim Deputy Clinical Chair for a six month period from 1 April 2017.

Future Commissioning across the Black Country

WCCG.1743 Dr Hibbs confirmed this report will be going to all four CCGs across the Black Country. She gave an overview of the report pointing out that it is important that we provide consistent leadership across the four CCGs in order to enable our collaboration to be effective as possible. A workshop took place on the 2 March 2017 bringing together the leadership teams of the four Black Country CCGs to develop the principles for collaboration across the Black Country and agreed the framework for a more detailed set of proposals.

The Accountable Officers and Chairs have agreed that the Joint Committee will meet monthly in order to provide the forum with delegated decision making. The Chair of the committee will rotate every 6 months amongst the Chairs of the CCGs. The committee will provide the mechanism for any regulatory requirements for shared CCG reporting, assurance or decision-making on a Black Country and West Birmingham Sustainability Transformation Plan (STP) basis.

A clear outcome of the workshop was a shared recognition of the importance of all of our staff and the value that we place in their commitment to securing the best possible healthcare for our population. We will therefore bring together our HR resources across the four CCGs to work together to establish a common HR approach to any collaborative arrangements we establish. Mr Oatridge emphasised the importance of valuing our staff. HR leads will meet together on a regular basis and report on these requirements to the Accountable Officers. Mr Hastings confirmed he will be part of this group.

Dr Hibbs confirmed regular updates will be reported to the Governing Body.

RESOLVED: That regular updates are brought back to Governing Body meetings.

Black Country Sustainability Transformation Plan (STP) update

WCCG.1744 Dr Hibbs reported a meeting is taking place on Thursday 16 March 2017 to review the STP and where we are going. A report will be brought back to the Governing Body meeting in April. Mr D Watts emphasised the importance of public engagement is outlined at this meeting. Ms E Learoyd stated she has raised this at the Transition Board and she will also pick this up at the next Health Watch meeting.

.

RESOLVED: That a further report is brought back to the Governing Body in April 2017.

Board Assurance Framework (BAF)

WCCG.1745 Ms M Garcha presented the report highlighting the number of risks on the risk register. Mr Oatridge expressed concern regarding the use of the word ‘extreme’. A discussion took place and it was agreed that this is discussed outside the meeting

Ms C Parker and Mr D Hughes arrived

Ms Garcha highlighted appendix 1 – Strategic Aims and Objectives 2017/2019.

RESOLVED:

(1) That the Governing Body approved the strategic aims and objectives.
(2) That the Governing Body approved the dummy BAF template.

Equality Delivery System2 (EDS2) Implementation Plan sign off

WCCG.1746 Ms Garcha gave an overview of the report. Ms Skidmore requested a more detailed analysis is forwarded to the management team. Ms Garcha confirmed quarterly reports will be provided and the next report will be due in June 2017.

RESOLVED:

(1) That the Governing Body agreed on the EDS2 self-assessment scores.
(2) That the Governing approved the EDS2 Portfolio of evidence.
(3) That the Governing agree to recommend that the EDS2 portfolio of evidence is published on the CCG website including a library of evidence that are stand along documents.
(4) That the Governing Body agreed to quarterly updates.

Environmental Sustainability Development Plan

WCCG.1747 Mr Hastings presented the report to outline the work carried out in 2016/17 in support of the sustainability agenda and seek the Governing Body sign off for the 2017/18 plan. Dr De Rosa stated we should all try to view papers electronically at meetings rather than having paper copies.

RESOLVED: That the Governing Body approves the work plan for 2017/18.

Transforming Care Partnership update

WCCG.1748 Mr D Hughes and Ms C Parker thanked the Governing Body for their invitation. They gave an overview of the key issues. The Black Country Transforming Care Partnership (TCP) comprises four CCGs, four local authorities and one specialised services commissioning hub. We are also working with the Birmingham TCP where boundaries overlap in West Birmingham.

Mr Hughes is the nominated finance lead. The Black Country TCP will aim to deliver care in a better way, whilst optimising the resource available. Ms Parker added that it is important that the service is the right

move for patients, carers and their families. Mr D Watts stated this is a challenging situation and Ms W Ewins has been engaged with this work and has concerns relating to people who are in secure settings. We have been feeding these concerns back and would like assurance these are addressed. Mr Hughes stated that the challenges are not specifically aimed at Wolverhampton. If there is other people we should be liaising with please let me know. He added if discharge dates are incorrect please let us know the correct information.

Ms Skidmore highlighted that this is a draft document and requested that the document is updated as Wolverhampton CCG do not have a pooled budget, however we have a good joint working relationship with the local authority. Mr Hughes confirmed that the £10.4m equates to 62 beds.

Dr Hibbs confirmed this is an important area and a number of questions can continue to be discussed in other forums. Mr Hughes confirmed a further report will be brought back to the Governing Body in the future.

Claire Parker, David Hughes and Wendy Ewins left

RESOLVED: That the above is noted.

Commissioning Committee

WCCG.1749 Dr J Morgans presented the report which is to provide the Governing Body with an update from the Commissioning Committee in February 2017. He highlighted the decommissioning of breast feeding. The Committee was informed that following a decision by the CCG to disinvest in the breastfeeding project at the Trust this has created some issues for Public Health who are still in contract with the Royal Wolverhampton Trust (RWT) for a service that is not viable. Ms Garcha added it is a core midwife's role and this is being actioned through the Clinical Quality Review Meetings and confirmed Public Health will be included in discussions.

RESOLVED: That the above is noted.

Quality and Safety Committee

WCCG.1750 Ms Garcha gave an overview of the report. She referred to the key issues of concern for noting. Since the report was written RWT have reported a further Never event. There are now five Never events for the current year and the CCG are currently awaiting a report. Black Country Partnership Foundation Trust have been rated as good and Dr De Rosa has written to them with his congratulations.

Dr De Rosa expressed concern regarding the number of Never events usually wrong side surgeries and procedures which is unacceptable. Ms Garcha confirmed check lists are in place and more training is taking place. Dr S Reehana added there is a large team why is the whole team getting it wrong, this needs to be looked into. Dr De Rosa requested RWT are made aware of our concerns.

RESOLVED: That the above is noted.

Finance and Performance Committee

WCCG.1751 Ms Skidmore gave an overview of the report. With regard to finance there have been no material changes and we remain on track to deliver our target position. Under the performance agenda RWT are struggling to meet a number of targets. She highlighted that they have now recruited into the Urology team so there may be progress around the cancer targets relating to urology.

RESOLVED: That the above is noted.

Audit and Governance Committee

WCCG.1752 Mr Oatridge presented the report. He pointed out that an internal audit has taken place which highlighted the risk management procedures and processes need some improvement. He confirmed that 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 risks are robust.

Mr Oatridge pointed out that the Governing Body have a meeting scheduled to take place on Tuesday 23 May 2017 at which the Audit and Governance Committee will be requesting that the accounts and annual report be signed off.

RESOLVED: That the above is noted.

Primary Care Joint Commissioning Committee

WCCG.1753 Mr Hastings gave a brief overview of the report.

RESOLVED: That the above is noted.

Primary Care Strategy Committee

WCCG.1754 Mr Marshall presented the report. He pointed out the current position regarding the New Models of Care.

RESOLVED: That the above is noted.

Communication and Engagement update

WCCG.1755 Dr De Rosa referred to the report which is for information.

RESOLVED: That the above is noted.

Minutes of the Quality and Safety Committee

WCCG.1756 RESOLVED: That the minutes are noted

Minutes of the Commissioning Committee

WCCG.1757 RESOLVED: That the minutes are noted.

Minutes of the Finance and Performance Committee

WCCG.1758 RESOLVED: That the minutes are noted.

Minutes of the Audit and Governance Committee

WCCG.1759 RESOLVED: That the minutes are noted.

Minutes of the Primary Care Joint Commissioning Committee

WCCG.1760 RESOLVED: That the minutes are noted.

Minutes of the Primary Care Strategy Committee

WCCG.1761 RESOLVED: That the minutes are noted.

Any Other Business

WCCG.1762 Dr H Hibbs formally thanked Dr Dan De Rosa for his work for the CCG. Dr De Rosa stated it has been a pleasure to work with all the staff at the CCG.

RESOLVED: That the above is noted.

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

WCCG.1763 There were no questions.

Date of Next Meeting

WCCG.1764 The Board noted that the next meeting was due to be held on **Tuesday 11 April 2017** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 3.25 pm

Chair..……..

Date ……

Wolverhampton Clinical Commissioning Group Governing Body

11 April 2017

Date of meeting	Minute Number	Action	By When	By Whom	Status
14.2.17	WCCG.1706	Emergency Preparedness, Resilience and Response (EPRR) – a final report is submitted to the Governing Body.	May/June 2017	Mike Hastings/ Tally Kalea	
14.3.17	WCCG.1743	Future Commissioning across the Black Country – regular updates will be reported to the Governing Body	2017	Helen Hibbs/Steven Marshall	
14.3.17	WCCG.1744	Black Country Sustainability Transformation Plan – a further report is brought back to the Governing Body	April	Helen Hibbs/Steven Marshall	

This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
11 APRIL 2017

Agenda item 6

TITLE OF REPORT:	Chief Officer Report
AUTHOR(s) OF REPORT:	Dr Helen Hibbs – Chief Officer
MANAGEMENT LEAD:	Dr Helen Hibbs – Chief Officer
PURPOSE OF REPORT:	To update the Governing Body on matters relating to the overall running of Wolverhampton Clinical Commissioning Group.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	• Assurance Review – The WCCG Executive Team met with NHS England representatives for the year end Assurance Review. • West Birmingham and Black Country Joint Committee - The first meeting of the West Birmingham and Black Country Joint Committee was held and a number of task and finish groups have been set up to enable the working arrangements of this Committee to be clearly defined.
RECOMMENDATION:	That the Governing Body note the content of the report.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	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.
2. Reducing Health Inequalities in Wolverhampton	

3. System effectiveness delivered within our financial envelope	

1. BACKGROUND AND CURRENT SITUATION

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

2. CHIEF OFFICER REPORT

2.1 Assurance Review

The Executive Team met with NHS England representatives for the end of year Assurance Review. The review covered major ongoing areas of discussion for the CCG and NHS England including the STP, provider performance and recovery plans for constitutional outcomes indicators (A&E, Cancer, Referral to Treatment (RTT), Delayed Transfers of Care (DTOC), QIPP (Quality, Innovation, Productivity and Prevention) delivery, Patient Involvement etc. We await the official rating for the Full Year 2016/17 which should be with us in July. At the meeting we were informed that the mid-year assurance rating was maintained at 'Green Star' (formerly 'Outstanding') and that Wolverhampton CCG is the only CCG in the West Midlands to have retained this highest level of assurance. Thanks are due to the whole staff group and CCG members for their hard work and support throughout 2016/17.

2.2 Health and Wellbeing Board

The Health and Wellbeing Board had a discussion around the future of commissioning, the Sustainability and Transformation Plan (STP) process and the development of a local place based commissioning model for Wolverhampton. It was acknowledged that this is a difficult time for the NHS as changes are developing and there was agreement to have this item as a standing item on the agenda. It is important that all partners are engaged in ongoing dialogue. A paper was also received around the recent living well, feeling safe event which was an awareness raising event around multiple offers of community based support and help available from many organisations. This was a positive day with 152 organisations represented and 182 attendees. The feedback was overwhelmingly positive.

2.3 Sustainability and Transformation Plan (STP)

A workshop of the senior leaders involved in the Birmingham and Black Country STP was held. It was agreed that the plan needs to be refreshed and more progress

needs to be made in certain areas. The forward view delivery plan is expected soon and will give further guidance around STPs.

2.4 Primary Care Delegation

The CCG has now formally begun operating as a fully delegated commissioner of Primary Care from 1 April. The first meeting of the new Primary Care Committee look place on 7 April, continuing with the programme of work from our previous joint commissioning arrangements. On the ground, CCG teams continue to work with colleagues from NHS England to ensure a smooth transition into the new arrangements. More details on these plans will be included in the delegated commissioning plan for the CCG, which will need to be completed by June 2017.

2.5 West Birmingham and Black Country Joint Committee

The first meeting of the West Birmingham and Black Country Joint Committee was held and a number of task and finish groups have been set up to enable the working arrangements of this Committee to be clearly defined. Discussion was held around specialised services and the Committee agreed that they would be interested in further collaboration with NHS England around this area.

2.6 IMT Infrastructure Refresh

NHS Wolverhampton CCG have run a number of projects to refresh the IT infrastructure over and above the usual five year hardware replacement programme. These have included the deployment of a dual monitor solution to GP's, the roll out of network enabled printers to increase resilience within practices and the final stage of the network infrastructure programme. Moving forward the CCG have started the JAYEX refresh project that looks to update and modernise the JAYEX auto arrival solution within practices and the remote working project that will provide every practice with a 4G enabled laptop capable of connecting to the practices GP Clinical System.

On a national level the CCG were selected as early adopters of GP Wi-Fi by NHS Digital and then went on to become the first CCG to deploy patient/public/staff Wi-Fi within our practices by March 2017.

2.7 Estates Programme

The Estates programme within Wolverhampton is currently being reviewed via a feasibility and prioritisation exercise which is being carried out by an independent company. In line with the GP 5 year Forward View and the on-going Estates strategy the CCG is proactively working towards providing a fit for purpose Primary Care estate.

3. CLINICAL VIEW

3.1. Not applicable to this report.

4. PATIENT AND PUBLIC VIEW

4.1. Not applicable to this report.

5. KEY RISKS AND MITIGATIONS

5.1. Not applicable to this report.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. Not applicable to this report.

Quality and Safety Implications

6.2. Not applicable to this report.

Equality Implications

6.3. Not applicable to this report.

Legal and Policy Implications

6.4. Not applicable to this report.

Other Implications

6.5. Not applicable to this report.

Name	**Dr Helen Hibbs**
Job Title	**Chief Officer**
Date:	**30 March 2017**

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**	
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**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/A**	
Any relevant data requirements discussed with CSU Business Intelligence	**N/A**	
Signed off by Report Owner (Must be completed)	**Dr Helen Hibbs**	**30/03/17**

This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Public Governing Body
11th April 2017

TITLE OF REPORT:	Current update on the BC STP
AUTHOR(s) OF REPORT:	Steven Marshall
MANAGEMENT LEAD:	Helen Hibbs
PURPOSE OF REPORT:	To advise GM members of the current status of the BC STP
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	Public
KEY POINTS:	• The FYFV next steps has recently been published which lays out the next steps for the STP • The 4 CCGs in the STP have already begun their agreed trajectory of collaboration
RECOMMENDATION:	For consideration and discussion
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	The STP has a key consideration in how services may be delivered in and underpin new models of care that support care closer to home and improve the management of Long Term Conditions
1. Improving the quality and safety of the services we commission	The intent is for the STP to improve the quality of the services delivered to patients
2. Reducing Health Inequalities in Wolverhampton	The intent is for the STP to reduce health inequalities both in Wolverhampton and across the Black Country
3. System effectiveness delivered within our financial envelope	The STP is designed to deliver collaborative systems working

1. BACKGROUND AND CURRENT SITUATION

1.1. The 5YFV (published October 14) laid out the challenge of how the health system might work in the future in order to address the quality and financial sustainability gap and proposed the creation of new delivery models of care – MCPs (Multi speciality Community Providers) and PACs (Primary and Acute Care system). The 5YFV operating plan, published in December of the same year, then laid out the creation of STPs which sought to consider place based commissioning at a more 'strategic' level i.e. a wider geographical footprint, in order to maximise economies of scope and scale and minimise clinical variation, for certain commissioned services.

1.2. On the 31st March the NHS issued "NEXT STEPS ON THE NHS FIVE YEAR FORWARD VIEW" in which on the chapter regarding STPs (pp.31-34) it is stated *"all STPs need a basic governance and implementation 'support chassis'"*

1.3. Under this specifically STPs will:

1.3.1. Form an STP board drawn from constituent organisations and including appropriate non-executive participation, partners from general practice, and in local government wherever appropriate

1.3.2. Establish formal CCG Committees in Common or other appropriate decision making mechanisms where needed for strategic decisions between NHS organisations

1.3.3. Where this has not already occurred, re/appoint an STP chair/leader

1.3.4. Ensure the STP has the necessary programme management support by pooling expertise and people from across local trusts

1.3.5. Be able to propose an adjustment to their geographical boundaries where that is thought appropriate by local bodies in agreement with NHS England

1.3.6. The corollary to not being prescriptive about STP structures is that the way to judge the success of STPs - and their constituent organisations - is by the results they are able to achieve

1.3.7. The full paper is attached as appendix 1

2. Current Status of BC STP and actions regarding these guidelines

2.1. The following actions have been undertaken at an STP level, following a joint leadership meeting on the 2nd March. This has been communicated to all members of staff

2.2. The formation of a Joint Committee

2.3. Establishment of Task and finish areas along with facilitators have been established as outlined below

Communications and engagement

- AO sponsor: Helen Hibbs
- Manager: Mike Hastings
- Purpose: To establish both standard communications relating to this agenda and any shared requirements for public engagement and/or consultation

Governance

- AO sponsor: Paul Maubach
- Manager: Sara Saville
- Purpose: To organise the governance of the joint committee, clinical board and the task and finish groups; and to evaluate the consequences of CCG statutory duties on any future arrangements

Finance

- AO sponsor: Andy Williams
- Manager: James Green
- Purpose: To develop a shared approach to financial planning and identify key financial risks to the Black Country system and consequential actions / review

Infrastructure including IM&T

- AO sponsor: Helen Hibbs
- Manager: Claire Skidmore
- Purpose: To determine the opportunities for joint working on the use of IM&T, estates and the Black County digital roadmap

Systems design and contractual frameworks

- AO sponsor: Paul Maubach
- Manager: Neill Bucktin

- Purpose: To establish the scope of services between local place and system-wide services; and develop the methodology for enabling each CCG to implement their placed-based model(s) of care

CCG collaboration

- AO sponsor: Andy Williams
- Manager: Sharon Liggins
- Purpose: To explore the opportunities for either the sharing of 'back office functions' and/or to collaborate of common systems and processes to improve the effectiveness of the four CCGs on current activities

2.4. The BC STP Sponsoring group also reiterated in principle the continuation of the major areas as identified within the original STP submission i.e. One 'Acute' system, One MH system, 4 local place based systems.

2.5. No formal appointment process or lead and/or programme support arrangements have been finalised as of yet

3. CLINICAL VIEW

3.1. N/A

4. PATIENT AND PUBLIC VIEW

4.1. Engagement and discussion will be necessary for the delivery of the STP

5. KEY RISKS AND MITIGATIONS

5.1. The paper is intended to prompt the discussion on risks

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. There will be as yet not fully explored financial consequences of a change in the local system dynamics

Quality and Safety Implications

6.2. New Models of Care will need to fully consider the quality and safety implications

Equality Implications

6.3. Equality will need to be considered in light of any proposed changes

Legal and Policy Implications

6.4. Guidance is not proposing any change to current legislation

Name: **Steven Marshall**
Job Title: **Director of Strategy and Transformation**
Date: **31/03/17**

ATTACHED:

Appendix 1

This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
11 APRIL 2017

Agenda item 9

TITLE OF REPORT:	Interim Arrangements – Audit and Governance and Finance and Performance Committee
AUTHOR(s) OF REPORT:	Peter McKenzie, Corporate Operations Manager
MANAGEMENT LEAD:	Claire Skidmore, Chief Finance and Operating Officer
PURPOSE OF REPORT:	This report asks the Governing Body to approve an interim arrangement for the Lay Member for Finance and Performance to act as Chair of the Audit and Governance Committee and for the Deputy Chair of the Audit and Governance Committee to deputise for them on the Finance and Performance Committee whilst the Lay Member for Audit and Governance is covering the Governing Body Chair vacancy.
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• Whilst the Lay Member for Audit and Governance is covering the CCG Chair Vacancy, it is not appropriate for him to act as Audit Chair. In particular, it is difficult for him to fully discharge the role of Conflict of Interest Guardian and the Governing Body will need to make alternative arrangements. • The Lay Member for Finance and Performance, as a Governing Body Member and former Member of the Audit and Governance Committee, is the most appropriate person to take this role on. • Cover will therefore be required for the substantive Lay role for Finance and Performance and the Deputy Chair of the Audit and Governance Committee is a qualified person available to take this role on for the interim period.
RECOMMENDATION:	**1. That Peter Price, Lay Member for Finance and Performance be appointed to act as interim Chair of the Audit and Governance Committee whilst the Lay Member for Audit and Governance is covering the Governing Body Chair** **2. That Les Trigg, Deputy Chair of the Audit and Governance Committee be co-opted on to the**

	Governing Body to cover the role of Lay Member for Finance and Performance for the Interim Period.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	[Outline how the report is relevant to the Strategic Aims and objectives in the Board Assurance Framework – See Notes for Further information]
3. System effectiveness delivered within our financial envelope	<u>Continue to meet our Statutory Duties and responsibilities</u> The responsibilities of the Audit and Governance Committee are set out in legislation. The Conflict of Interest Guardian role is established through statutory guidance. Taking proactive steps to ensure these roles are fulfilled will help to ensure that the CCG meets these obligations.

1. BACKGROUND AND CURRENT SITUATION

1.1. Following the decision of the Governing Body's decision to appoint the Lay Member for Audit and Governance as Interim Chair of the Governing Body, alternative arrangements need to be made to cover his substantive role as Chair of the Audit Committee.

1.2. In addition to ensuring that chairing arrangements are in place for key Audit and Governance Committee meetings over the upcoming months, including those dealing with the sign off of accounts, it will be necessary for the role of Conflict of Interest Guardian to be covered. This is a statutory role established through the national guidance on managing Conflicts of Interest

2. PROPOSED APPROACH

2.1. As the Chair cannot continue to act as Audit Chair, it is proposed that the Lay Member for Finance and Performance take this role on an interim basis. As a former member of the Audit and Governance Committee he has demonstrated both the skills and experience to take on the Audit Chair's role. This will also ensure that a suitable member of the Governing Body covers the role of Conflict of Interest Guardian.

2.2. In order to take on the Audit and Governance Committee role, backfill arrangements will be required for the role of Finance and Performance Committee. Due to the crossover of skills and experience required, it is recommended that the Governing Body co-opts Les Trigg, the current Deputy Chair of the Audit and Governance

Committee on to the Governing Body to take on this role in the interim period. Mr Trigg has served on the Audit and Governance Committee since 2013 and has a strong background in financial matters.

2.3. Both Mr Trigg and Mr Price have been approached and have confirmed that they are willing to serve in these respective capacities. As this is an interim arrangement, Mr Trigg will remain as a member of the Audit and Governance Committee. As a consequence of these arrangements, Mr Price will also chair the CCG's remuneration committee and Mr Trigg will join the Primary Care Committee to act as its Deputy Chair.

3. CLINICAL VIEW

3.1. Not applicable.

4. PATIENT AND PUBLIC VIEW

4.1. Not applicable.

5. KEY RISKS AND MITIGATIONS

5.1. This report does not relate to any specific risks on the risk register. The recommendation mitigates potential risks associated with the Chair of the Audit Committee and Conflict of Interest Guardian role not being covered.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. These interim arrangements will involve backfill remuneration in line with the substantive Lay Member posts for Audit and Governance and Finance and Performance. This will be met from the existing running costs budget underspend as a result of vacancies.

Quality and Safety Implications

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

Equality Implications

6.3. There are no Equality implications arising from this report.

Legal and Policy Implications

6.4. The recommendations in this report ensure that the CCG will have arrangements in place to meet the requirements of statutory guidance in relation to Conflicts of Interest Guidance.

Other Implications

6.5. There are no other implications arising from this report.

Name Peter McKenzie
Job Title Corporate Operations Manager
Date: April 2017

RELEVANT BACKGROUND PAPERS

NHS England, Managing Conflicts of Interest Guidance

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	Date
Clinical View	**N/a**	
Public/ Patient View	**N/a**	
Finance Implications discussed with Finance Team	**Claire Skidmore**	**29/03/2017**
Quality Implications discussed with Quality and Risk Team	**N/a**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/a**	
Information Governance implications discussed with IG Support Officer	**N/a**	
Legal/ Policy implications discussed with Corporate Operations Manager	**Report Author**	**29/03/2017**
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/a**	
Any relevant data requirements discussed with CSU Business Intelligence	**N/a**	
Signed off by Report Owner (Must be completed)	**Peter McKenzie**	**29/03/2017**

This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
11th April 2017

Agenda item 10

TITLE OF REPORT:	Better Care Fund (BCF) Planning submission 2017-19
AUTHOR(s) OF REPORT:	Andrea Smith
MANAGEMENT LEAD:	Andrea Smith
PURPOSE OF REPORT:	To inform Governing Body of the recently published 2017-19 Integration and Better Care Fund Policy Framework and to request Chair's Action for approval of the BCF Plan due to restricted timeframes
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• 2017-19 Integration and Better Care Fund Policy Framework was published on 31st March 2017 outlining requirements of the 2017-19 plan. • The Planning guidance is yet to be published but early indications are that the submission date for the plan is 9th May resulting in the inability to present to Governing Body ahead of submission • Delegated approval is requested (should the guidance dictate signed approval for 1st submission) in order for the plan to submitted within the given timescales. In previous year's delegated approval was given to Dr Helen Hibbs, Accountable Officer and Claire Skidmore, CFO.
RECOMMENDATION:	That delegated approval is agreed in order for the plan to be submitted within the given timeframes. The submitted plan and update on approval will be presented to June 2017 Governing Body meeting
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	[Outline how the report is relevant to the Strategic Aims and objectives in the Board Assurance Framework – See Notes for Further information]

1. Improving the quality and safety of the services we commission	The BCF Plan will detail how we intend to improve the quality of services we commission in Wolverhampton.
2. Reducing Health Inequalities in Wolverhampton	The BCF Plan aims to reduce health inequalities in Wolverhampton by ensuring that by mapping health and social are data the most appropriate services are commissioned to meet the demand.
3. System effectiveness delivered within our financial envelope	Utilising a pooled budget enables us to manage and commission services more effectively.

N.B. Please divide the rest of the report into Paragraphs, using numbering for easier referencing.

1. BACKGROUND AND CURRENT SITUATION

1.1. The Policy Framework and Planning Guidance for Better Care Fund have been delayed significantly with the guidance originally being due in Autumn 2016. The Policy Framework was published on Friday 31st March (attached). We are still unclear as to the publication date of the Planning guidance but are led to believe by the regional team that this will be published w/c 10th April.

1.2. The date for submission of the plan has not been confirmed but we are told that this is likely to be 9th May for the first submission.

1.3. If the 9th May is the first submission date we will be unable to bring the plan to Governing Body for approval prior to submission therefore delegated approval authority is being sought.

2. Development of Plan and Assurance Process

2.1. The plan is currently being drafted by members of the BCF Programme team from both WCCG and City of Wolverhampton Council.

2.2. We are led to believe that the first submission date is 9th May. There is then planned to be a local assurance process, followed by a moderation process undertaken by regional teams taking approximately 2 weeks.

2.3. Plans will be either:-

- "compliant" – approval by H&WBB required
- "on track" – some issues are raised and feedback will be given but the expectation is that the plan will be compliant by the 2nd submission.
- "off-track" – some significant concerns which will be escalated and support offered by regional team.

2.4. Following feedback of the assurance process there is likely to be a further two weeks to amend and finalise plans before the 2nd submission date. This second submission has to be signed by Health and Wellbeing Board. The process for this, given the restricted timeframe is being developed between CCG and CWC Programme team.

2.5. The plan will be a 2 year plan 2017-19

2.6. The national conditions have been reduced from 8 to 4. Whilst we still need to include information in the plan on all 8, the 4 conditions that we will be required to report against are:-

- Jointly agreed plans
- Maintain Social Care
- Commissioning out of hospital services
- Managing Transfers of Care

2.7 With regard to the Pooled budget we are informed that the CCG minimum contribution must increase in line with CCG budgets and that the Improved Better Care Fund (IBCF) which includes additional funding to social care announced in the Autumn and Spring budgets will be included within the pool and that the plans on how to spend this funding must be agreed between Local authorities and CCGs. The Disabilities Facilities Grant (DFG) will also, again, be included within the pool.

2.8 Regular meetings are underway between executives at both CCG and CWC to determine the financial value of the pooled budget. Claire Skidmore and Steven Marshall both attend these meetings.

3. CLINICAL VIEW

3.1. Input into the development of the plan will be sought from members of the Clinical Reference Group.

4. PATIENT AND PUBLIC VIEW

4.1. The BCF programme aligns with feedback form the public regarding moving care closer to home

5. KEY RISKS AND MITIGATIONS

5.1. Risk that the plan will be submitted prior to full approval and discussion with Governing Body members, however updates and the draft plan can be shared with members by email and delegated approval will provide assurance that the plan aligns with CCG objectives and financial plans.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. Both Chief Finance Officer and Deputy Chief Finance Officer are actively involved in the development of the BCF plan and the content of the Pooled Budget.

Quality and Safety Implications

6.2. The Draft plan will be shared with Head of Quality and Risk prior to submission

Equality Implications

6.3. N/A for this report

Legal and Policy Implications

6.4. As in previous years the pooled budget will be underpinned by a Section 75 agreement.

Other Implications

6.5. N/A for this report

Name: Andrea Smith
Job Title: Head of Integrated Commissioning
Date: 3rd April 2017

ATTACHED:

2017 -19 Integration and Better Care Fund Policy Framework (DoH. March 2017)

RELEVANT BACKGROUND PAPERS
(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 View	**N/A**	**03.04.17**
Public/ Patient View	**N/A**	**03.04.17**
Finance Implications discussed with Finance Team	**Claire Skidmore/Lesley Sawrey**	**03.04.17**
Quality Implications discussed with Quality and Risk Team	**Steven Forsyth**	**03.04.17**
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	**03.04.17**
Information Governance implications discussed with IG Support Officer	**N/A**	**03.04.17**
Legal/ Policy implications discussed with Corporate Operations Manager	**Peter McKenzie**	**03.04.17**
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/A**	**03.04.17**
Any relevant data requirements discussed with CSU Business Intelligence	**N/A**	**03.04.17**
Signed off by Report Owner (Must be completed)	**Andrea Smith**	**03.04.17**

This page is intentionally left blank

Department of Health

Department for Communities and Local Government

2017-19 Integration and Better Care Fund

Policy Framework

March 2017

Title: Integration and Better Care Fund Policy Framework 2017-19
Author: Social Care, Ageing and Disability / Integration, Local Devolution and Policy Improvement / 11120
Document Purpose: Policy
Publication date: 03/17
Target audience: This document is intended for use by those responsible for delivering the Better Care Fund at a local level (such as clinical commissioning groups, local authorities and health and wellbeing boards) and NHS England.
Contact details: Integration, Local Devolution and Policy Improvement Unit Richmond House Whitehall London SW1A 2NS Bettercarefund@dh.gsi.gov.uk

Published to gov.uk, in PDF format only.

www.gov.uk/dh

2017-19 Integration and Better Care Fund

Policy Framework

Prepared by the Department of Health and the Department for Communities and Local Government

Contents

Executive Summary

Why Integrate?

People need health, social care, housing and other public services to work seamlessly together to deliver better quality care. More joined up services help improve the health and care of local populations and may make more efficient use of available resources.

How is Integration being done?

There is no single way to integrate health and care. Some areas are looking to scale-up existing initiatives such as the New Care Models programme and the Integration Pioneers. Others are using local devolution or Sustainability and Transformation Plans as the impetus for their integration efforts.

One part of the solution – the Better Care Fund

The Better Care Fund is the only mandatory policy to facilitate integration. It brings together health and social care funding, with a major injection of social care money announced at Spring Budget 2017. This policy framework for the Fund covers two financial years to align with NHS planning timetables and to give areas the opportunity to plan more strategically. Details of the financial breakdown are below:

Better Care Fund funding contribution (£bn)	2017-18	2018-19
Minimum NHS (clinical commissioning groups) contribution	£3.582	£3.65
Disabled Facilities Grant (capital funding for adaptations to houses)	£0.431	£0.468
New grant allocation for adult social care (Improved Better Care Fund)*	£1.115	£1.499
Total	£5.128 billion	£5.617 billion

*Combined amounts announced at Spending Review 2015 and Spring Budget 2017

Many areas choose to pool more than is required. For 2017-19, there are four national conditions, rather than the previous eight:

1. **Plans to be jointly agreed**
2. **NHS contribution to adult social care is maintained in line with inflation**
3. **Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care**

4. **Managing Transfers of Care** (a new condition to ensure people's care transfers smoothly between services and settings).

Beyond this, areas have flexibility in how the Fund is spent over health, care and housing schemes or services, but need to agree how this spending will improve performance in the following four metrics: **Delayed transfers of care; Non-elective admissions (General and Acute); Admissions to residential and care homes; and Effectiveness of reablement.**

Going beyond the Better Care Fund through Graduation

The Better Care Fund is intended to encourage further integration and 90% of areas say it has already had a positive impact on integration locally. For the most integrated areas, there will be benefits in graduating from the Fund to reduce the reporting and oversight to which they are subjected. We are planning to test the graduation process with a small number of advanced areas (6 to 10) in a 'first wave', in order to develop our criteria for graduation for all areas. We are therefore inviting 'Expressions of Interest' from areas that think they are exemplars of integration, by 28th April 2017.

Agreeing a local vision of integration

As part of Better Care Fund planning, we are asking areas to set out how they are going to achieve further integration by 2020. We would encourage areas to align their approach to health and care integration with Sustainability and Transformation Plan geographies, where appropriate. This may be an exact match (e.g. Greater Manchester) or it may be smaller units within Sustainability and Transformation Plans. The focus may also be on commissioning integration (e.g. North East Lincolnshire) or through Accountable Care Systems or Organisations that bring together provision (e.g. Northumberland). What matters is that there is locally agreed clarity on the approach and the geographical footprint which will be the focus for integration.

Measuring progress on integration

To help areas understand whether they are meeting our integration ambition, we are seeking to rapidly develop integration metrics for assessing progress, particularly at the interface where health and social care interact. These will combine outcome metrics, user experience and process measures. Following the development of the metrics and an assessment of local areas, we will ask the Care Quality Commission to carry out targeted reviews in a small number of areas, starting as soon as is practical from May 2017. These reviews will be focused on the interface of health and social care.

Need more detail?

Further information on everything here can be found in the full Integration and Better Care Fund Policy Framework 2017-19.

Introduction

This document sets out the story of integration of health, social care and other public services. It provides an overview of related policy initiatives and legislation. It includes the policy framework for the implementation of the statutory Better Care Fund (BCF) in 2017-19, which was first announced in the Government's Spending Review of 2013 and established in the Care Act 2014. And it sets out our proposals for going beyond the BCF towards further integration by 2020. Whilst there will now be no separate process for integration plans, we will provide a set of resources, integration models and indicators for integration to help local areas towards our shared goal of person-centred, coordinated care.

This Policy Framework has been developed by the Department of Health (DH), Department for Communities and Local Government (DCLG), Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), and NHS England.

The case for integrated health and care services

Today, people are living much longer, often with highly complex needs and multiple conditions. These needs require ongoing management from both health and care services, which combine both the medical and social models of care. As our population ages and the financial pressures on the health and care system increase, we need to be better at providing proactive, preventative care in community settings, so that people can be supported to live at home for longer and avoid the need for commissioned health and care services.

More joined up and sustainable services help improve the health and care of local populations and may make more efficient use of available resources (i.e. by reducing avoidable hospital admissions, facilitating timely discharge, and improving people's experiences of care). Integration needs to reflect the different strengths that the NHS and social care bring to an integrated response, including the role of social services of promoting and supporting independence, inclusion and rights as far as possible, invigorating wider community services and supporting informal carers.

People want services to work together to provide them with person-centred coordinated care. National Voices set out a narrative for person-centred care, which sums up what we are working to achieve: "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."[1] This translates into positive interactions with health and care services, and better experiences for individuals as illustrated by Figure 1.

[1] http://www.nationalvoices.org.uk/publications/our-publications/narrative-person-centred-coordinated-care

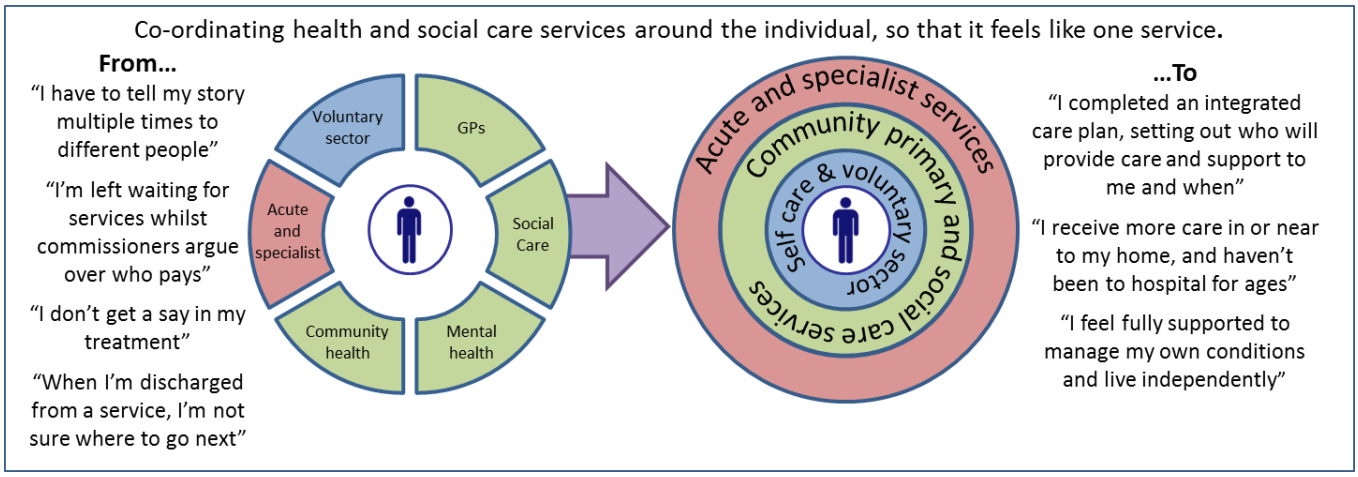


Figure 1: Co-ordinating health and care services around the individual

1. Integration to date

Integration is not a new goal and there have been initiatives over a number of years (see Figure 2).

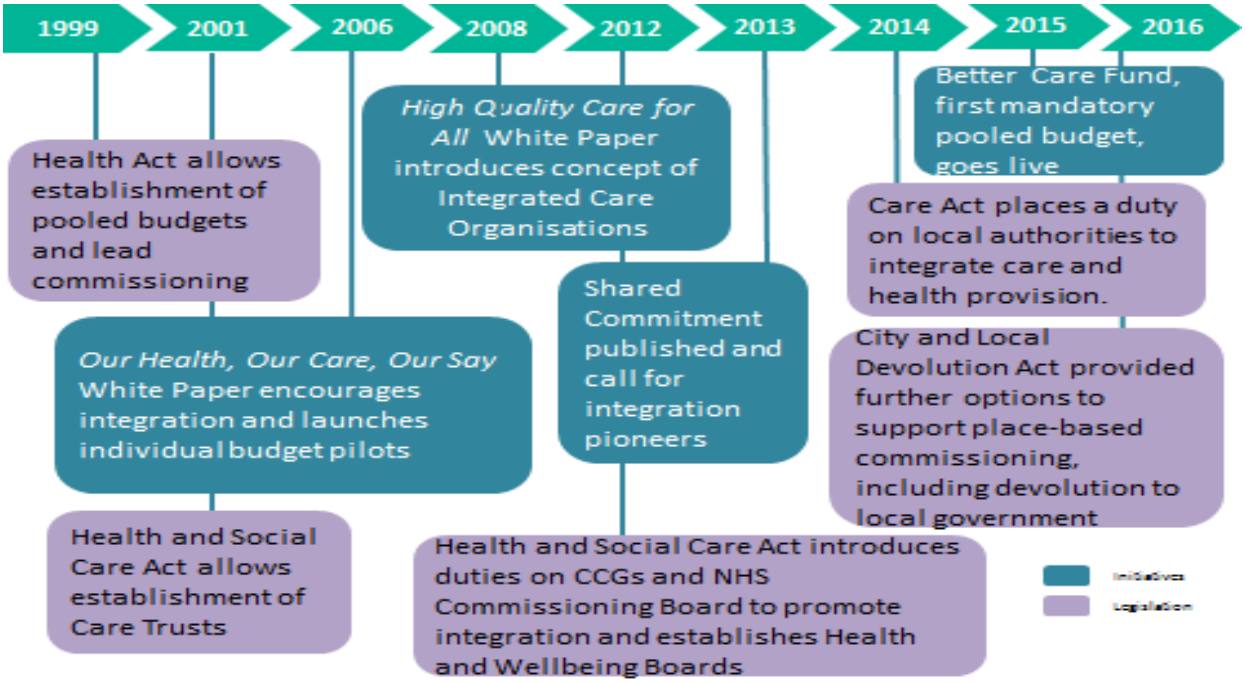


Figure 2: Key integration initiatives and enabling legislation

The Coalition Government and partners set out collective intentions on integration in Integrated Care and Support: Our Shared Commitment in 2013.[2] This showed how local areas can use existing structures such as **Health and Wellbeing Boards** to bring together local authorities, the NHS, care and support providers, education, housing services, public health and others to make further steps towards integration.

This collaboration with 12 national partners was backed by a call for areas wanting to lead the way to apply to become an 'Integrated Care Pioneer'. We identified excellent examples of joined-up care happening in different ways up and down the country and the **Integrated Care Pioneers Programme** was launched to learn from the most innovative areas and to encourage change from the bottom up. The second annual report[3] of the Pioneers summarises some of the recent learning and experiences, and the Pioneers' resource centre[4] contains a collection of tools, information and useful links.

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf
[3] https://www.england.nhs.uk/pioneers/wp-content/uploads/sites/30/2016/01/pioneer-programme-year2-report.pdf
[4] https://www.england.nhs.uk/pioneers/resource-centre/

More recently, the LGA, ADASS, NHS Confederation and NHS Clinical Commissioners have developed a shared vision document, Stepping up to the place[5] for a fully integrated system based on existing evidence. This framework describes the essential characteristics of an integrated system to improve the health and wellbeing of local populations, and paves the way for integration to happen faster and to go further, so that integrated, preventative, person-centred care becomes the norm.

There is also a growing recognition of the important contribution of housing to integration. A national Memorandum of Understanding to Support Joint Action on Improving Health through the Home[6] has been signed by a spectrum of organisations including: DH, DCLG, NHS England, ADASS and the LGA, along with members of the wider housing sector. The proposals set out in the Housing White Paper – Fixing our Broken Housing Market[7] – also underline the Government's commitment to do more to provide the homes we need for all in our society, including older people and those with care and support needs.

[5] http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Stepping%20up%20to%20the%20place_Br1413_WEB.pdf
[6] https://www.adass.org.uk/media/3957/health-and-housing-mou-final-dec-14.pdf
[7] https://www.gov.uk/government/collections/housing-white-paper

2. Integration now and the wider policy context

Just as progress has already been made on integration, there are a number of current initiatives across the health and care system that contribute towards this goal.

Announced in June 2013, the **Better Care Fund (BCF)** brings together health and social care budgets to support more person-centred, coordinated care. In the first two years of the BCF, the total amount pooled has been £5.3bn in 2015-16 and £5.8bn in 2016-17.

The BCF offers a good opportunity to have shared conversations, and to consider issues from different perspectives, particularly how BCF plans can support the delivery of wider objectives and strategies around health and social care. In particular, every health and care system in England has produced a **Sustainability and Transformation Plan (STP),** providing the system-level framework within which organisations in local health and care economies can plan effectively and deliver a sustainable, transformed and integrated health and care service. Local areas should ensure the financial planning and overall direction of travel within BCF plans and the local STP(s) are fully aligned.

The **vanguards**, which are part of NHS England's new care models programme[8], have clear plans for managing demand more effectively across the local health and care system and reducing costs, at the same time as improving outcomes for patients and users. The vanguards programme has published two frameworks that cover population-based integrated models – the **Multi-speciality Community Providers (MCPs) and the Primary and Acute Care Systems (PACs)**.[9] Many of these two types of vanguards include social care as well as pursuing integration within health services. All areas are encouraged to take action against the core elements described in the models where these support local objectives around the integration of health and care services. Scaling up of PACS and MCPs in a small number of STP areas will create Accountable Care Organisations, with further details in the Next Steps on the NHS Five Year Forward View.

Local devolution deals can add impetus to all of these initiatives, offering local areas the opportunity to go beyond the integration of health and social care and drawing in other local government services such as housing, planning, skills, justice, and transport. This provides opportunities for local areas to further tailor public services around individual needs and also to tackle the wider determinants of health. Figure 3 shows how multiple integration initiatives interact, for example, within Greater Manchester.

[8] https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf
[9] https://www.england.nhs.uk/wp-content/uploads/2016/09/pacs-framework.pdf and https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf

Figure 3 – Integration initiatives in Greater Manchester

There is a growing evidence base on the contribution that **housing** can make to good health and wellbeing. At a system level, poor housing costs the NHS at least £1.4bn per annum. And there are also costs to local government and social care. On an individual level, suitable housing can help people remain healthier, happier and independent for longer, and support them to perform the activities of daily living that are important to them – washing and dressing, preparing meals, staying in contact with friends and family.

The increase in funding for the **Disabled Facilities Grant (DFG)** – and the decision to move it into the BCF in 2015-16 – is recognised as an important step in the right direction. Further action to support people into more suitable accommodation, and to adapt existing stock, is also to be welcomed.

The Department of Health is also currently working with NHS England, Local Government and others to improve the support available to informal **carers**. Supporting informal carers also supports those they care for: improving outcomes for both parties, enabling people to live independently in the community for longer and reducing impact on commissioned services. All areas are therefore encouraged to consider how BCF plans can improve the support for carers. In doing so, they may wish to make use of *'An Integrated Approach to Identifying and Assessing Carer Health & Wellbeing'*[10], an NHS England resource that promotes and supports joint working between adult social care services, NHS commissioners and providers, and voluntary organisations.

Within an area, a number of initiatives can also contribute towards overall system integration. These are not sufficient to full integration of health and social care, but can offer important contributions to key cohorts of patients and service users. For example:

[10] https://www.england.nhs.uk/wp-content/uploads/2016/05/identifying-assessing-carer-hlth-wellbeing.pdf

- Some local areas are also taking action on **'Integrated Personal Commissioning'** (IPC), whereby individuals experience holistic, personalised care and support planning, and an option for them to commission their own care using a personal budget or direct payment arrangements that combine funding from health, social care and education. IPC is being progressed by nine demonstrator areas (covering 20 CCGs and 12 local authorities) that are leading the way in developing a practical operating framework to enable wider replication, with a further 10 early adopters set to join the programme by March 2017.[11]

  NHS England expects that IPC will become a mainstream model of care for around 5 per cent of the population, enabling the expansion of personal health budgets and integrated personal budgets at scale. IPC is expected to be operational in 50% of STP footprints by 2019. Some Demonstrator sites (i.e. Luton and Stockton on Tees) are incorporating their work on IPC into BCF plans, using personal health budgets and integrated personal budgets to create more stable, coordinated care at home and in the community for high risk groups. Others parts of the country are also encouraged to consider this approach.

- Learning from the six **Enhanced Health in Care Homes** (EHCH) vanguard sites suggests that action to provide joined up primary, community and secondary health and social care to residents of care and nursing homes, as well as those living in the wider community, can have significant benefits. These include transforming the quality of care, reducing costs and activity levels, and supporting relationship-building at local level. Some parts of the country (i.e. East and North Hertfordshire and others) are already building in work around EHCH into their BCF plans and other parts of the country are encouraged to do the same. For more details, please see the 'Enhanced Health in Care Homes Framework'.[12]

[11] https://www.england.nhs.uk/commissioning/ipc/sites
[12] https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf

3. Integration now and the Better Care Fund 2017-19

This Policy Framework for the Better Care Fund (BCF) covers two financial years (2017-19) to align with NHS planning timetables and to give areas the opportunity to plan more strategically. In 2017-18, the BCF will be increased to a mandated minimum of £5.128 billion and £5.617 billion in 2018-19.[13] The local flexibility to pool more than the mandatory amount will remain. Further details of the financial breakdown are set out in Table 1 below.

The main change to the Framework from last year is inclusion of significant amounts of local authority social care grant funding. Some of this was announced at the 2015 Spending Review, with an additional £2 billion over three years announced at Spring Budget 2017. There will be grant conditions on this new money to ensure it has the expected impact at the care front line.

In developing this framework, we have listened to feedback from local areas about the need to further streamline the processes around planning, assurance and performance reporting. There is also a halving of the number of national conditions that areas are required to meet through their BCF plans - reduced from eight to four. We have also set out more clearly, the requirements around the social care national condition.

The national conditions that areas will need to meet in their plans for 2017-18 and 2018-19 are: **plans to be jointly agreed; NHS contribution to adult social care is maintained in line with inflation; agreement to invest in NHS commissioned out of hospital services; and managing transfers of care**. The detailed requirements for each condition are set out in **Annex A**.

The removal of some national conditions from 2016-17 does not reflect a downgrading of the importance of these policies and we expect them to underpin local BCF plans. For example, all areas should be working to embed 7-day services across the health and care system. Shared information, interoperable IT and joint care assessments are critical enablers to deliver integrated services - therefore, we expect every area to continue taking action to build on the progress made in the last two years. In **Annex B** we have set out what you can do to keep up the momentum.

Statutory and Financial Basis of the Better Care Fund

The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the BCF. It allows for the Mandate to NHS England to include specific requirements to instruct NHS England over the BCF, and NHS England to direct Clinical Commissioning Groups to pool the necessary funding.

[13] These are indicative figures only.

Better Care Fund in 2017-18

The Mandate to NHS England for 2017-18 requires NHS England to ring-fence £3.582 billion within its overall allocation to Clinical Commissioning Groups to establish the BCF in 2017-18. The Mandate was published on 20th March 2017.[14]

The remainder of the £5.128bn BCF in 2017-18 will be made up of the £431m Disabled Facilities Grant (DFG) and £1.115bn new grant allocation to local authorities to fund adult social care, as announced in the 2015 Spending Review and Spring Budget 2017. Both grants are paid directly from the Government to local authorities.

As in the previous two years, the NHS contribution to the BCF includes funding to support the implementation of the Care Act 2014. Funding previously earmarked for reablement (£300m) and for the provision of carers' breaks (£130m) also remains in the NHS allocation.

Better Care Fund in 2018-19

The Mandate to NHS England for 2017-18 also denotes an indicative ring-fence of £3.65bn from allocations to Clinical Commissioning Groups for the establishment of the BCF in 2018-19. The actual amount will be confirmed via the Mandate for 2018-19, which will be published in winter 2017-18.

The remainder of the £5.617bn BCF in 2018-19 will be made up of the £468m DFG and an indicative amount of £1.499bn new grant allocation to local authorities to fund adult social care, both of which will be paid directly from the Government to local authorities.

As in 2017-18, funding previously earmarked for reablement (£300m) and for the provision of carers' breaks (£130m) remains in the NHS contribution.

Table 1: BCF funding contributions in 2017-19

Better Care Fund funding contribution (£bn)	2017-18	2018-19
Minimum NHS (clinical commissioning groups) contribution	£3.582	£3.65
Disabled Facilities Grant (capital funding for adaptations to houses)	£0.431	£0.468
New grant allocation for adult social care (Improved Better Care Fund)	£1.115	£1.499
Total	£5.128 billion	£5.617 billion

[14] https://www.gov.uk/government/publications/nhs-mandate-2017-to-2018

Conditions of access to the Better Care Fund

The amended NHS Act 2006 gives NHS England the powers to attach conditions to the amount that is part of Clinical Commissioning Group allocations (as discussed earlier, these are £3.582bn in 17-18, and an indicative amount of £3.65bn in 18-19). These powers do not apply to the amounts paid directly from Government to local authorities.

For the DFG, the conditions of usage are set out in a Grant Determination Letter, due to be issued by DCLG in April. This references the statutory duty on local housing authorities to provide adaptations to those disabled people who qualify, and sets out other relevant conditions.

For the new grant allocation to local authorities to fund adult social care, the conditions of usage will also be set out in a Grant Determination Letter. This will also be issued by DCLG in April, though a draft version of the conditions has been shared in March, for information.

National Conditions for 2017-19

In 2017-19, NHS England will require that BCF plans demonstrate how the area will meet the following national conditions:

- **Plans to be jointly agreed;**
- **NHS contribution to adult social care is maintained in line with inflation;**
- **Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care; and**
- **Managing Transfers of Care**

The refreshed definitions of these national conditions are set out at **Annex A.**

NHS England will also set the following requirements, which local areas will need to meet to access the CCG elements of the funding:

- A requirement that the BCF is transferred into one or more pooled funds established under section 75 of the NHS Act 2006; and
- A requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group(s).

Under the amended NHS Act 2006, NHS England has the ability to withhold, recover or direct the use of CCG funding where conditions attached to the BCF are not met, except, as mentioned above, for those amounts paid directly to local government. The Act makes provision

at section 223GA(7) for the mandate to NHS England to include a requirement that NHS England consult Ministers before exercising these powers. The 2017-18 Mandate to NHS England confirms that NHS England will be required to consult the Department of Health and the Department for Communities and Local Government before using these powers.

Disabled Facilities Grant

In two-tier areas decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government should be passed down by the county to the districts (in full, unless jointly agreed to do otherwise) to enable them to continue to meet their statutory duty to provide adaptations and in line with these plans; as set out in the DFG Grant Determination Letter due to be issued by DCLG in April 2017.

New grant for adult social care (announced in the 2015 Spending Review and Spring Budget 2017 as 'Improved Better Care Fund' (iBCF) funding)

The Government's Spending Review in 2015 announced new money for the BCF of £105m for 2017-18, £825m for 2018-19 and £1.5bn for 2019-20. The Spring Budget 2017 subsequently increased this to £1.115bn for 2017-18, £1.499bn for 2018-19 and £1.837bn for 2019-20. The Government will require that this additional Improved Better Care Fund (iBCF) funding for adult social care in 2017-19 will be pooled into the local BCF. This funding does not replace, and must not be offset against the NHS minimum contribution to adult social care.

The new iBCF grant will be paid directly to local authorities via a Section 31 grant from the Department for Communities and Local Government. The Government will attach a set of conditions to the Section 31 grant, to ensure it is included in the BCF at local level and will be spent on adult social care. The final conditions will be issued in April. However, a draft has been shared with areas in March. The draft conditions of use of the Grant can be summarised as:

1. Grant paid to a local authority under this determination may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.

2. A recipient local authority must:

    a) pool the grant funding into the local BCF, unless an area has written Ministerial exemption;

    b) work with the relevant Clinical Commissioning Group and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and

c) provide quarterly reports as required by the Secretary of State.

3. The Government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans have been locally agreed.

In terms of the wider context, the funding is also intended to support councils to continue to focus on core services, including to help cover the costs of the National Living Wage, which is expected to benefit up to 900,000 care workers. This includes maintaining adult social care services, which could not otherwise be maintained, as well as investing in new services, such as those which support best practice in managing transfers of care.

Local authorities will be required to confirm that spending of the BCF money provided at Spending Review 2015 and Spring Budget 2017 will be additional to prior plans for social care spending, via a Section 151 Officer letter.

The assurance and approval of local Better Care Fund plans

As in 2016-17, plans will be developed locally in each Health and Wellbeing Board area by the relevant local authority and Clinical Commissioning Group(s). Plans will be assured and moderated regionally in line with the operational planning assurance process set out in the Integration and Better Care Fund Planning Requirements, published by NHS England and the Local Government Association.

Recommendations for approval of overall BCF plans will be made following moderation of regional assurance outcomes by NHS England and local government. Plans will be approved and permission to spend the CCG minimum contribution to the BCF will be given once NHS England and the Integration Partnership Board have agreed that the conditions attached to that funding have been met.

Local authorities are legally obliged to comply with grant conditions. The NHS Act 2006 (as amended by the Care Act 2014) allows NHS England to direct the use of the CCG elements of the fund where an area fails to meet one (or more) of the BCF conditions. This includes the requirement to develop an approved plan. If a local plan cannot be agreed or other National Conditions are not met, any proposal to direct use of the CCG elements of the Fund will be discussed with the Integration Partnership Board.

National performance metrics

As in 2015-16 and 2016-17, local areas are asked to agree and report metrics in the following four areas:

- Delayed transfers of care;
- Non-elective admissions (General and Acute);
- Admissions to residential and care homes; and
- Effectiveness of reablement

The detailed definitions of these metrics will be set out in the Integration and Better Care Fund Planning Requirements.

We are no longer requiring the national collection of a locally proposed metric.

Better Care Fund support offer in 2017-19

In implementing the BCF from 2017-18 to 2018-19, the joint Better Care Support team hosted by NHS England will continue to:

- Provide support to local areas to ensure effective implementation of agreed plans;
- Build an intelligence base to understand the real impact of the BCF on delivering integration;
- Support local systems to enable the successful delivery of integrated care in 2017-19 by capturing and sharing learning, building and facilitating networks to identify solutions;
- Promote and communicate the benefits of health and social care integration;
- Monitor the ongoing delivery of the BCF – including quarterly reporting on national metrics and spending; and
- Support areas that are proposing to graduate or have graduated from the BCF.

4. Integration now - Graduating from the Better Care Fund

Overview

The Government's Spending Review 2015 set out that "areas will be able to graduate from the existing Better Care Fund (BCF) programme management once they can demonstrate that they have moved beyond its requirements, meeting the government's key criteria for devolution."

It is the Government's ambition that all areas will be able to work towards graduation from the BCF to be more fully integrated by 2020, with areas approved in waves as they demonstrate maturity and progress towards greater integration. The best areas are showing that greater levels of integration bring positive benefits in terms of improving people's health, wellbeing and experience of care, particularly in wrapping services around people's needs and shifting the focus to keeping people well and happy at home, with reduced demand for hospital and other health and care services.

These areas can apply for 'earned autonomy' from the BCF programme management. Graduation will mean that we will have a different relationship with these local areas; with reduced planning and reporting requirements and greater local freedoms to develop agreements appropriate to a more mature system of health and social care integration. This will include a bespoke support offer for areas that graduate, in addition to them no longer being required to submit BCF plans and quarterly reports.

We are planning to test the graduation process with a small number of areas (6 to 10) in the first instance. We are inviting areas that believe they can demonstrate that they meet the criteria for graduation now to put themselves forward prior to the deadline for submission of first plans, with a view to graduating from the BCF in this first wave.

Subsequent waves of areas will have the opportunity to graduate over the course of this spending review period. Departments, the LGA and NHS England will work with graduated areas to role-model how integration can support better outcomes for populations across health, social care and housing.

A "first wave" of Better Care Fund graduation

We have no set targets for the numbers of areas that graduate from the existing BCF programme management in each year. In the first round, we are planning to test graduation with a small number of areas (between 6 and 10), and will use this learning to refine the criteria and process going forward.

Graduation proposals should be made, at minimum, across an entire Health and Wellbeing Board geography, but could be aligned to Sustainability and Transformation Plan (STP)

footprints or devolution deal sites, as long as all relevant Health and Wellbeing Boards included in the proposal are supportive.

The eligibility criteria are set out below. Areas interested in participating in the first wave of graduates should benchmark themselves against these criteria and discuss their interest with their Better Care Manager.

The process of graduation will utilise sector-led improvement principles, supporting areas through peer review and development. This will culminate in a "graduation panel", which will provide face-to-face support and challenge to local areas to agree the conditions for graduation.

Eligibility criteria for Better Care Fund graduation

To keep the application process simple, all partners in an area wishing to apply for graduation will need to complete an Expression of Interest and demonstrate that they:

a) **Have in place a sufficiently mature system of health and social care with evidence of:**
   - Strong shared local political, professional, commissioner and community leadership;
   - An agreed system-wide strategy for improving health and wellbeing through health and social care integration to 2020. The government supports a range of models of health and social care integration, as set out in Chapter 5. You should reference your choice of model in your integration strategy or action plans and their links to wider health and local government strategies; and
   - A robust approach to managing risk, including adequate financial risk management arrangements proportionate to the level of risk in the system, for example, if any CCG is subject to financial directions, a clear appraisal of any additional risk and approach to managing it.

b) **Can demonstrate the application is approved by all signatories required by BCF planning**

c) **Provide evidence of improvement and/or approach to improving performance on BCF national performance metrics and how graduation will enable the area to accelerate improvement on these metrics. This should include current performance data and stretch targets.**

d) **Set out plans to pool an agreed amount greater than the minimum levels of the BCF or align the commissioning of an equivalent or greater scope of services. Set out plans to maintain joint investment in integrated services, including:**
   - Maintaining the NHS contribution to social care and NHS commissioned services in line with inflation;
   - Maintaining additional contributions from CCGs and local authorities to the pooled fund, in addition to the 'improved Better Care Fund' grant funding to local government; and

- Continuing to meet grant conditions attached to the newly allocated funding within the Improved Better Care Fund.

e) Are committed to a 'sector-led improvement' approach in which they are willing to act as peer leaders, working with national partners to support other areas looking to graduate.

Selection criteria

As the first wave is testing the process, we will use the Expressions of Interest and other available information, including the following additional criteria, to select a small pool of 6-10 applicants, as follows:

a) The applicants commit and have the capacity to participate in the selection process which is set out below, participate in the pilot evaluation and share learning with peers and with national organisations supporting integration work.

b) The applicants have discussed their proposal with their local Better Care Manager.

c) The pilot cohort covers a range of different care model types as set out in Chapter 5.

d) The pilot cohort covers a spread of geographical locations and local authority type.

The selection process will include graduation workshops to help local leaders identify the steps necessary to graduate from the BCF and progress integration, in line with the 2015 Spending Review commitments. The workshops are based on the existing LGA sector-led improvement model, and will involve a half-day session for senior local health and local government leaders; these workshops will run in May and June, in order to complete the pilot in the agreed timeframe. The process will culminate in graduation panels (in early-to-mid July) with representatives from Department of Health, Department for Communities and Local Government, NHS England, Local Government Association, and Association of Directors of Adult Social Services, and will agree with local leaders, clear, measurable and transparent objectives and milestones for integration locally to 2020. We also intend to develop a dedicated package of support, building on the learning and experience of sites which have graduated from the pilot.

We are seeking areas which have made the most progress in moving beyond the requirements of the BCF. We recognise that the restricted number of pilot areas is likely to mean some areas are unsuccessful. We do understand that this will be disappointing for those areas not selected, but subsequent graduation waves will not be restricted in numbers in the same way. In addition those areas which are not selected for the pilot can continue to prepare for subsequent waves.

Expression of Interest process and timelines

- Applicants should submit to England.bettercaresupport@nhs.net an Expression of Interest, which demonstrates how local organisations meet the eligibility criteria a) to e) above by 5pm on 28th April 2017; this should include an indication of the discussion with their local Better Care Manager, which should take place before 19th April 2017.
- All applications will be assessed by the selection panel, with results communicated by 10th May 2017.
- Graduation workshops will run in May and June, with graduation panels taking place in early-to-mid July.

Guidance on submitting an Expression of Interest

The form should specifically address the eligibility criteria outlined in a) to e) above. Any submitted documents, including any covering letters, must not be longer than 6 pages, and have no embedded or attached appendices. Any attached or embedded documents will not be considered by the selection panel.

The Expressions of Interest will be assessed by a panel of representatives from the Department of Health, Department for Communities and Local Government, NHS England, Local Government Association, and Association of Directors of Adult Social Services. Its decision will be based on the evidence provided against eligibility criteria a) to e), with adjustments made to ensure a fair selection of pilots across geography, care model and local authority type in order to maximise the potential for learning from the pilots.

The support offer

We will put in place an ongoing support offer for areas, before, during and after the process of graduation. This will include:

- **Before –** Seminars, workshops or individual support for areas preparing for graduation (second and subsequent waves), including peer support from areas that have graduated;
- **During -** Advice and support for areas shortlisted for graduation to develop the core essential characteristics for integration including those required as evidence for graduation;
- **After -** Support for a peer network of graduated areas to share experience and evidence of what is working;

Once an area has been selected for graduation, we will aim to support them to achieve and/or maintain their integration vision. Areas that have 'graduated' from the BCF will continue to be subject to the normal local authority and CCG reporting requirements on finance and performance. We will develop with the first wave the format and process for providing a self-certifying annual report. In the unforeseen circumstances of serious financial or performance

issues or a breakdown in local partnership's ability to realise their integration plan, it may be necessary to reinstate some or all of the BCF programme management. This would be considered a last resort to support local leaders. Local areas would be given adequate advance notice, before any assurance or reporting requirements are reinstated.

BCF graduates will be at the forefront of demonstrating how integration of health and care is becoming a reality by 2020 and we expect that early graduates will work with national partners to share learning with others and provide leadership in delivering fuller integration by 2020.

5. Integration future - Integration to 2020

Overview

At the Spending Review 2015, the Government announced its ambition to integrate health and social care by 2020 so that it feels like one service. As noted by the Nuffield Trust there "is no one model of integrated care that is suited to all contexts, settings and circumstances".[15]

The ways local areas integrate will be different, and some parts of the country are already demonstrating different approaches, which reflect models the government supports. For example:

- **Greater Manchester –** a devolution area pooling health and social care budgets within 10 HWB localities. Where there are clear benefits, services will be commissioned across the footprint through the joint commissioning board (comprising the CCGs, local authorities and NHS England). Each locality has its own individual plan for integrating services which feeds into the overarching health and social care strategy.
- **North East Lincolnshire –** a lead commissioner model, in which the CCG exercises the Adult Social Care functions on behalf of the local authority;
- **Northumberland –** a single Accountable Care Organisation (ACO), taking on responsibility for general practice, primary care, hospital and community services, adult social care and mental health services.[16]

	Joint commissioning	Lead commissioning	Accountable Care Organisation (ACO)[17]
Characteristics	Some or all CCG/LA commissioning decisions made jointly. Budgets (and other resources) pooled or aligned in line with extent of joint commissioning.	One body exercises some or all functions of both the CCG and the LA, with the relevant resources delegated accordingly.	CCG and LA pay a set figure (possibly determined by capitation) to an Accountable Care Organisation to deliver an agreed set of outcomes for all health and care activity for the whole population, using a multi-year contract. The ACO decides what services to purchase to deliver those outcomes. MCPs and PACs are types of ACOs.

[15] Nuffield Trust, An overview of integrated care in the NHS. What is integrated care? (London: Nuffield Trust, 2011), 20.
[16] Northumberland is a PACs vanguard site, but the ACO goes well beyond simply combining primary and secondary acute care.
[17] M McClellan et al., Implementing Accountable Care to achieve Better Health at a Lower Cost, WISH 2016 http://www.wish-qatar.org/wish-2016/forum-reports

An integrated health and social care service should have full geographical coverage, with clear governance and accountability arrangements. As part of this, we would encourage areas to align their approach to health and care integration with STP geographies, where appropriate. This may be supplemented by initiatives for particular groups, such as Enhanced Health in Care Homes and Integrated Personal Commissioning.

The Government recognises the integration efforts that are already happening, including through the Better Care Fund (BCF), STPs and local devolution. There will be no separate process for integration plans. **Instead, we will simply require local areas to set out how they expect to progress to further integration by 2020 in their BCF 17-19 returns.**

Next Steps

To help areas understand whether they are meeting our integration ambition, we will develop integration metrics for assessing progress, particularly at the interface where health and social care interact. This will combine outcome metrics, user experience and process measures. The metrics will build on work already carried out on behalf of Government (see Annex C) and the Integration Standard tested on the Government's behalf by the Social Care Institute for Excellence (SCIE) found at Annex D. SCIE found that the standard identified helpful integration activities such as risk stratification and multi-disciplinary community teams, but was process-focussed and did not tell the whole integration story. We therefore want to bring elements of the standard into the wider integration scorecard. SCIE's full report is available here: www.scie.org.uk/integrated-health-social-care/integration-2020/research

Further work involving SCIE and key stakeholders will develop these integration metrics. If you have any thoughts on what to include in these, please email: Bettercarefund@dh.gsi.gov.uk

Following the development of the metrics we will ask the Care Quality Commission (CQC) to carry out targeted reviews in a small number of areas, starting as soon as is practical from May 2017. These reviews will be focused on the interface of health and social care and will not cover wider council social care commissioning. This should lead to a tailored response to ensure those areas facing the greatest challenges can improve rapidly.

Other actions will include:

a) Consideration of Section 75 arrangements

The Department of Health, working with NHS England, is now considering what further changes could be made to secondary legislation to support more integrated, place-based approaches to health and social care, for example:

- The commissioning functions that can be included in scope
- The governance and partnership working arrangements that are permissible, for example Joint Committees

Before NHS England can make arrangements involving combined authorities and local authorities for example, regulations would need to be made prescribing those bodies for the purposes of such arrangements. The Department is also considering whether further amendments to the section 75 partnership regulations would support local areas to extend the benefits of partnership working as they take forward their integration vision.

b) Developing our evidence base on integration, through independent evaluation and sector-led engagement

We will build on our evidence base on what good integration looks like through:

- **The final report of the system-level evaluation of the Better Care Fund will be ready in winter 2017-18.** An interim report is expected in spring 2017, including a typology analysis of integration activities, initial findings from the comparative evaluation, and a BCF policy background paper (a documentary analysis of official BCF literature).

- **Learning from LGA's sector-led support using the Integration 'self-assessment' tool**[18] developed by LGA, ADASS, NHS Confederation and NHS Clinical Commissioners. The peer-led tool assesses local leaders' readiness, capacity and capability to integrate. We will build on this to facilitate graduation panels.

- **NHS England and NHS Improvement evaluation of the New Care Models Programme.** There is a wide range of national, local and independent evaluation of the NCM. Evaluations are progressing at pace.

- **DH and CQC testing the feasibility of a national survey of people's experience of integrated care.** This will be piloted in 2017-18 with a view to national roll out in the future.

Resources:

The LGA has developed a library of resources, signposting local areas to evidence, case studies, tools and resources which will support the development of integration ambitions locally.[19] The resource is organised around the essential integration characteristics, such as leadership, governance, prevention, housing and planning, co-production, care models and workforce. Organisations may also find the slides on Integration, produced by consulting firm Oliver Wyman, a useful resource.[20]

[18] http://www.local.gov.uk/documents/10180/7632544/1.10+Stepping+up+to+the+place+-+integration+self-assesment+tool+WEB.pdf/017681db-bec4-405d-b51d-4ff6f930227d
[19] http://www.local.gov.uk/integration-better-care-fund/-/journal_content/56/10180/8026967/ARTICLE
[20] http://www.oliverwyman.com/our-expertise/insights/2016/nov/global-health-strategy-hub.html

Annex A: Further information on the national conditions for 2017-19

NATIONAL CONDITION	DEFINITION
Condition 1: **Plans to be jointly agreed**	Local areas must ensure that their Better Care Fund (BCF) Plan covers the minimum of the pooled fund specified in the BCF allocations spreadsheet, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area. The plans should be signed off by the Health and Wellbeing Board itself, and by the constituent councils and Clinical Commissioning Groups. The Disabled Facilities Grant (DFG) will again be allocated through the BCF. As such, areas are required to involve local housing authority representatives in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing. In two-tier areas decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government should be passed down by the county to the districts (in full, unless jointly agreed to do otherwise) to enable them to continue to meet their statutory duty to provide adaptations and in line with these plans. During these discussions, it will be important to continue to meet local needs for aids and adaptations, whilst also considering how adaptation delivery systems can help meet wider objectives around integration. For both single tier and two tier authorities, areas are required to set out in their plans how the DFG funding will be used over the two years. In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with groups likely to be affected by the use of the fund (including health and social care providers) in order to achieve the best outcomes for local people.
Condition 2: **NHS contribution to adult social care is maintained in line with inflation**	For 2017/18 and 2018/19, the minimum contribution to adult social care will be calculated using the assured figures from 2016/17 as a baseline. This will apply except where a Health and Wellbeing Board secures the agreement of the Integration Partnership Board to an alternative baseline. The NHS contribution to adult social care at a local level must be increased by 1.79% and 1.9% (in line with the increases applied to the money CCGs must pool) in 2017-18 and in 2018-19 respectively. Local areas can opt to frontload the 2018-19 uplift in 2017-18 and then carry over the same level of contribution in 2018-19 as in 2017-18. The funding must be used to contribute to the maintenance of adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition, the Department of Health wants to provide flexibility for local areas to determine how this investment in adult social care

	services is best used. The additional funding for adult social services paid directly to local authorities by the government in each year (please refer to page 17) does not replace, and cannot not be offset against, the NHS minimum contribution to adult social care.
Condition 3: **Agreement to invest in NHS commissioned out of hospital services, which may include 7 day services and adult social care**	Local areas should agree how they will use their share of the £1.018 billion in 2017/18 and £1.037 billion in 2018/19 that had previously been used to create the payment for performance fund (in the 2015-16 BCF). This should be achieved by funding NHS commissioned out-of-hospital services, which may include 7-day services and adult social care, as part of their agreed BCF plan. This can also include NHS investment in the high impact change model for managing transfers of care (linked to compliance with national condition 4), although CCGs can commission these services from funding outside of this ringfence. Local areas can choose to put an appropriate proportion of their share of the £1.018bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including 7-day services and adult social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 2016-17). Further guidance to support local areas on deciding whether to hold back a proportion of funds as part of a risk share agreement will be provided in the Integration and Better Care Fund Planning Requirements.
Condition 4: **Managing Transfers of Care**	All areas should implement the High Impact Change Model for Managing Transfer of Care[21] to support system-wide improvements in transfers of care. Narrative plans should set out how local partners will work together to fund and implement this and the schemes and services commissioned will be assured through the planning template. Areas should agree a joint approach to funding, implementing and monitoring the impact of these changes, ensuring that all partners are involved, including relevant Accident and Emergency Delivery Boards. Quarterly reports will be provided, as required by the Department of Health and the Department for Communities and Local Government.

[21] Including arrangements for a Trusted Assessor model, as per the following link: http://www.local.gov.uk/documents/10180/7058797/Impact+change+model+managing+transfers+of+care/3213644f-f382-4143-94c7-2dc5cd6e3c1a

Annex B: Maintaining progress on the 2016-17 national conditions

We have made changes to the national conditions and reduced the number of conditions to reflect wider changes in the policy and delivery landscape.

For the policy areas that are no longer national conditions of the Better Care Fund (BCF) in 17-19 (see table below), we encourage areas to continue taking action through their BCF plans or other local agreements to ensure these policy priorities and critical enablers for integration continue to feature in local planning and delivery.

National condition	Update for 2017-19 Better Care Fund planning
1. Plans to be jointly agreed	This is a condition for 2017-19 (see Annex A)
2. NHS contribution to adult social care is maintained in line with inflation.	This is a condition for 2017-19 (see Annex A)
Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admission to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Improving services through the implementation of the 7-day service clinical standards remains an important priority.[22] All areas should be working to make progress on implementing the 4 priority clinical standards, supported by NHS England and NHS Improvement, so that by April 2018, 50% of patients have access to these standards of care every day of the week with this rising to everyone by 2020. Sustainability and Transformation Plans are providing an opportunity for areas to come together to consider the delivery of 7-day services across geographical areas. Although not a requirement for accessing BCF funding in 2017-19, BCF areas should continue to make progress locally, building on the action taken in 2016-17, on implementing standard 9 of the 7- day hospital service clinical standards which concerns the transfer of patients to community, primary and social care. Standard 9 sets out that: 'Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken, 'Academy of Medical

[22] https://www.england.nhs.uk/ourwork/qual-clin-lead/seven-day-hospital-services/the-clinical-case/

	Royal Colleges (2012): Seven day consultant present care'. Without the timely transfer of patients across settings of care there can be detriment to both existing hospital patients and newly-arriving patients. All BCF areas should work together to avoid unnecessary delays in patient pathways, including taking the actions to reduce delayed transfers of care set out in the section on DTOC below.
Better data sharing between health and social care, based on the NHS number	Data sharing is no longer a condition of the BCF but it remains an important enabler to delivery of BCF or wider integration commitments. To enable effective information sharing for direct care, Parliament introduced the Safety and Quality Act in 2015 which now makes it a legal requirement to share information where it is likely to facilitate the provision of health or care services and is in the individuals' best interests. The Safety and Quality Act also now makes it a legal requirement to use a consistent identifier (such as the NHS number) to support local information sharing. There are examples of where leadership commitment is enabling information sharing at a local level. In addition, through Local Digital Roadmaps, local areas are outlining ambitions for the use of information sharing and technology to support the delivery of care. There are existing examples across the country of where local areas are joining up local systems to give a single health and care record to support the delivery of direct care. These approaches will enable improved coordination of care and support information sharing across health and care settings. The National Data Guardian has also published a review of data security, consent and opt outs across health and care. The report proposed a set of ten data security standards for the health and care system and made a series of recommendations to support information sharing. This includes a commitment to refresh the current Information Governance Toolkit, so that it becomes a portal to support organisations across health and social care to demonstrate increasing resilience and compliance with the standards. Local areas should consider how best to implement these recommendations in conjunction with national policy and services such as CareCERT. The review builds on the previous two Caldicott reports to emphasise the

	importance of building public trust in data security and information sharing, and encouraging public bodies to ensure they engage with citizens regarding how their information is shared.
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	This is no longer a condition of the BCF; however, BCF plans should have embedded within them, an integrated and proactive approach to planning and managing care with other health and care professionals.
Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans	This is no longer a condition of the BCF but areas should engage with groups likely to be affected by the use of the fund (including health and social care providers) in order to achieve the best outcomes for local people (as set out in condition 1 for 2017-19)
3. Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care	This is a condition for 2017-19 (see Annex A)
Agreement on local action plans to reduce delayed transfers of care (DTOC)	There is an improved condition around Managing Transfers of Care (National Condition 4), which requires areas to implement the High Impact Change Model for Managing Transfers of Care. Areas should agree a joint approach to funding, implementing and monitoring the impact of these changes, including setting out the intended impact on reducing delayed transfers of care. This will also support the target of a reduction in total delayed transfers of care to 3.5% by September 2017 (recognising existing variation between areas), which is referenced in the Mandate to NHS England for 2017-18.

Annex C: Draft Interface Metrics

Proposed scorecard for measuring effectiveness of social and healthcare interfaces

A Main performance indicators

A1 NEL admissions (65+) per 1,000 65+

A2 NEL admissions (65+) with length of stay >30 days per 1,000 65+

A3 Emergency readmission (65+) per 1,000 emergency admissions 65+

A4 Institutionalisation bed days (65+) per 1,000 65+

A5 DTOC – overall and due to social care placement or package per 1,000 65+

B Supporting overarching indicator

B1 Index of 'User reported quality of life' and 'Proportion of people feeling supported to manage their LTC'

C Contextual indicator

C1 Index of multiple deprivation (IMD)

Additional contextual indicators to collect in the future:
- Public health and social care spend per capita for 65+
- Proportion of 65+ with shared care records in place which are accessible by all care manage teams

Annex D: Integration Standard

	Objective	Improvement to person's experience	System change needed to deliver this objective
1	**Digital inter-operability**	"I have access to a Digital Integrated Care Record that moves with me throughout the health and care system. All professionals involved in my care have access to this record (with the appropriate safeguards in place to protect my personal data)"	• Areas reach **digital maturity**, including universal use of the NHS number as the primary identifier and fully interoperable IT across providers and commissioners.
2	**Resource targeted at key cohorts to prevent crises and maintain wellbeing**	"If I am at risk of emergency hospital admission, I will receive the right care at the right time to help me to manage my condition and to keep me out of hospital." "If it would benefit me, I will be able to access a personal budget, giving me greater control over money spent on my care."	• Areas use health and social care data to **risk stratify** their populations, identifying those most at risk of unplanned admissions and allocating resources according to need. • Areas will allow greater access to **Integrated Personal Commissioning**, for identified groups who could benefit. • Areas use **capitated budgets** where appropriate
3	**Value for money**	"I receive the best possible level of care from the NHS and my Local Authority."	• Areas deliver against a **clear plan for making efficiencies** across health and care, through integration.
4	**Single assessment and care plans**	"If I have complex health and care needs, the NHS and social care work together to assess my care needs and agree a single plan to cover all aspects of my care."	• Areas use **multi-disciplinary integrated teams** and make use of professional networks to ensure high-quality joined-up care is delivered in the most appropriate place seven days a week.
5	**Integrated community care**	"My GP and my social worker or carer work with me to decide what level of care I need, and work with all of the appropriate professionals to make sure I receive it."	
6	**Timely and safe discharges**	"If I go into hospital, health and social care professionals work together to make sure I'm not there for any longer than I need to be."	
7	**Social care embedded in urgent and emergency care**	"If I have to make use of any part of the urgent and emergency care system, there are both health and social care professionals on hand when I need them".	

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
11th April 2017

Agenda item 11

TITLE OF REPORT:	**Commissioning Committee – Reporting Period March 2017**
AUTHOR(s) OF REPORT:	Dr Julian Morgans
MANAGEMENT LEAD:	Mr Steven Marshall
PURPOSE OF REPORT:	To provide the Governing Body of Wolverhampton Clinical Commissioning Group (CCG) with an update from the Commissioning Committee in March 2017.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	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.
RECOMMENDATION:	That the report is noted.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	[Outline how the report is relevant to the Strategic Aims and objectives in the Board Assurance Framework – See Notes for Further information]
1. Improving the quality and safety of the services we commission	
2. Reducing Health Inequalities in Wolverhampton	
3. System effectiveness delivered within our	

financial envelope	

1. BACKGROUND AND CURRENT SITUATION

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 March 2017.

2. MAIN BODY OF REPORT

2.1. Contract & Procurement Update

The Committee was presented with an overview and update of key contractual issues in relation to Month 10 (January 2017) for activity and finance.

Royal Wolverhampton NHS Trust

A&E - The Trust's Month 11 (February 2017) A&E performance showed a 3% improvement from the previous month.

E-discharge - The Trust remains challenged on achieving dispatch of e-discharge summaries within 24 hours for both ward and assessment areas.

Cancer 62 days - The Trust remains challenged in this area and has advised that they will not achieve the 85% target for the whole of next year.

Finance and Activity Position - Overall, the contract is c£2.8m over plan.

Exception Reporting Proposal – The CCG's intention is to request a monthly exception report for deviation against agreed contractual standards to ensure a consistent standardised approach with regards to discussing underperformance against contractual targets.

Performance Sanctions for Month 10 (January) - £95,950.

Business Cases for Fines/ MRET/ Readmissions – The Trust has confirmed that business cases will be completed.

Black Country Partnership Foundation Trust

Performance Sanctions – The Trust has agreed to the £5,000 sanction that will be applied following a drop in performance in relation to Safeguarding Adults Level 3 training.

SQPR - Delayed Transfers of Care remain an issue. However, there has been significant performance in this area with the Local Authority working with the CCG and DTOC is down to 10%.

CQUIN – BCPFT have requested a written partnership agreement with RWT to confirm the 2017-19 CQUIN that they have signed up to with regards to Mental Health patients presenting in A&E.

Data Quality Improvement Plan (DQIP) - BCPFT have confirmed that they are submitting all mandatory fields into the Mental Health Minimum Dataset and provided evidence of this.

Nuffield

Contract issues (Nuffield) – An issue exists with the activity reports being submitted and the data submitted via SUS. The two reports are not matching. A letter has been sent to request assurance that this will be rectified. The letter has been acknowledged and the CCG is awaiting a response.

Urgent Care Centre

Vocare Limited have been issued with a contract performance notice for a number of areas, including safeguarding, outstanding actions, timeliness of submission documents, accuracy of documents and Serious Incident issues. A remedial action plan has been requested.

As a result of the significant under plan activity, the CCG will be invoicing Vocare to claw back the financial difference for the 2016/17 year, before year end.

Vocare has been sanctioned for the month of January in relation to breaches for Duty of Candour and Serious Incident reporting. Vocare has contested the £10,000 sanction for Duty of Candour but the CCG's view is that this should stand.

Falls Service Specification

Following approval at the Committee in September 2016, the Committee was presented with an interim specification to be varied into the Acute Contract for 2017/18 whilst the CCG develop a more responsive model and undertake a procurement exercise during 2017/18. This was approved by the Committee.

Action – Governing Body are asked to note the update report provided.

2.2. **Commissioning Committee Annual Report 2016/17**

The Committee was asked to consider and comment on the Commissioning Committee draft Annual Report for 2016/17.

Action – That the above is noted.

2.3. **Resuming the Provision of Therapy Services in Step Down**

The Committee was asked to consider and approve the resumption of a therapy service in step down provision for the following reasons:

- A significant number of patients that utilise the step down bed based care, after an acute hospital admission, require a level of therapy assessment or intervention. Delays in accessing this in a timely manner has the potential to impact on the rehabilitation potential of a patient; particularly if they have been in a step down bed for a significant period of time.
- The number of patients waiting for therapy input, as a percentage of the total number of patients in step down, has markedly increased over recent months. This is the impact of the decision taken to remove the funding for 3 posts which previously supported this aspect of care

The Committee was provided with assurance that the service would be more responsive and that this would be managed through strict KPI's within the specification.

Approval was given for the CCG to fund the dedicated therapy support which includes 2 WTE Band 6 Therapists and 1 WTE Band 4 Therapy Assistant.

Action – That the above is noted.

3. RECOMMENDATIONS

- Receive and discuss the 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 March 2017**

WOLVERHAMPTON CCG
Governing Body
11th April 2017

Title of Report:	**Executive Summary from the Quality and Safety Committee**
Report of:	Steven Forsyth, Head of Quality and Risk
Contact:	Steven Forsyth, Head of Quality and Risk
Governing Body 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 Governing Body
Relevance to Board Assurance Framework/Strategic Objectives:	1. Improving the quality and safety of the services we commission 2. Reducing health inequalities in Wolverhampton 3. System effectiveness delivered within our financial envelope

Key issues of concern for noting

	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	RAG
SBAR issues escalated in 2016 Report received, monitor for 3 months	1	• Delayed diagnoses • Delayed treatment • Sub-optimal care (transfer of patient) • NE Quality Visits 14/11/16 • Review in May 2017	
Pressure Injury Grade 3/4	1	Close monitoring	
Increased HSMR and SHMI	2	Latest HSMR and SHMI (July15-June16) increased. Full programme of monitoring in place	
Health Acquired Infections- CDiff	1	Potential risk of increased incidence and potential harm RWT has reached its annual target, monthly CDiff back to trajectory (Nov – Jan) for close monitoring	
HCAI- CPE and others	2	Mycobacterium chimaera: infections linked to bypass machine, national issue with manufacturer being addressed, local patient look back review in progress CPE, numbers rising as per national picture, improved accountability framework and increased focus	
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.	
Vocare	2	Vocare issues concerning quality of data and safeguarding cover. Escalated meeting on 9th March with Accountable Officer and CEO of Vocare. CQC visit completed March 2017.	
Safeguarding	2	RWT designated and named Dr cover for Safeguarding Children, LAC and CDOP is not as robust. Whilst posts are covered and there are no gaps, substantive plans for recruitment are not known. This has been escalated by contract letter sent to RWT on 3rd March requesting immediate assurance BCP interim safeguarding medical cover till March 13th, then substantive Dr coming into role	
CQC General Practice RWT/BCPFT	1	2 practices are being supported for 'requires improvement' RWT RI plan in place and BCPFT rating is now 'Good'	

1.0 BACKGROUND AND CURRENT SITUATION

The CCG Governing Body delegates the quality and safety oversight to its Quality and Safety Committee, which meets on a monthly basis. This report is a material summation of the last Committee meeting 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

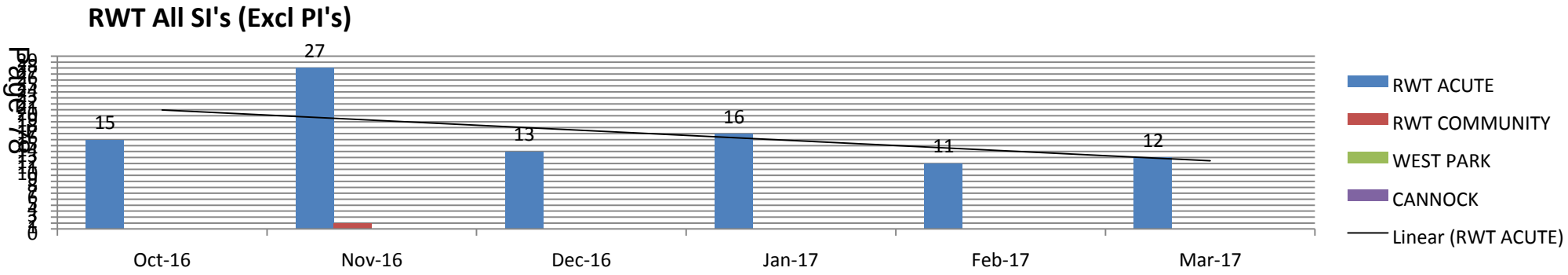
Weekly Exception Reports

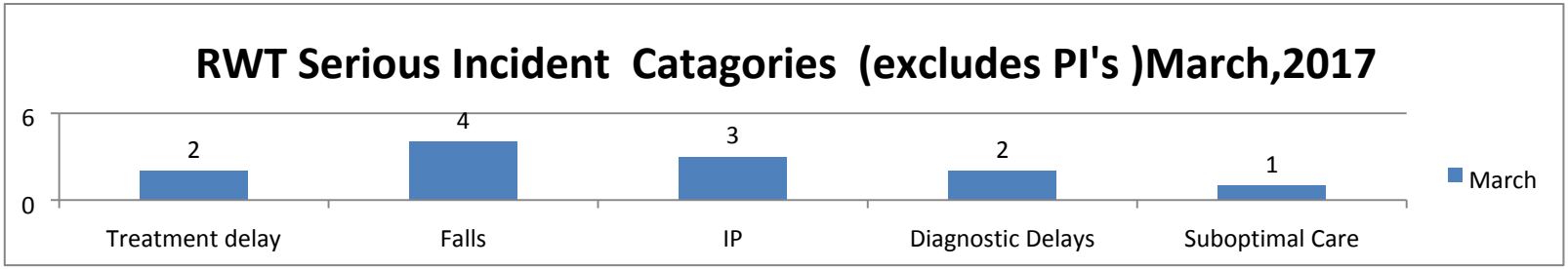
There are two homes in the City that are closed due to staff and resident influenza. The home is maintaining safety and standards of care and the Infection Control Team are advising and supporting resilience.

4.0 ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST

The Governing Body is asked to note the following:

a) Serious Incidents





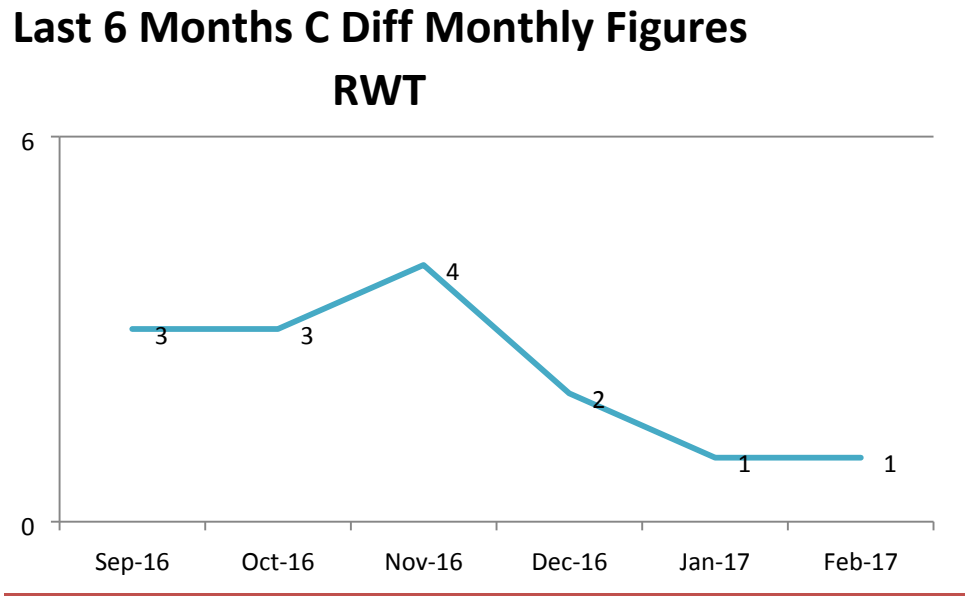
12 serious incidents were reported by RWT in this reporting period and a breakdown of these SI's has been given in the graph above.

4.1 Infection Control Serious Incidents

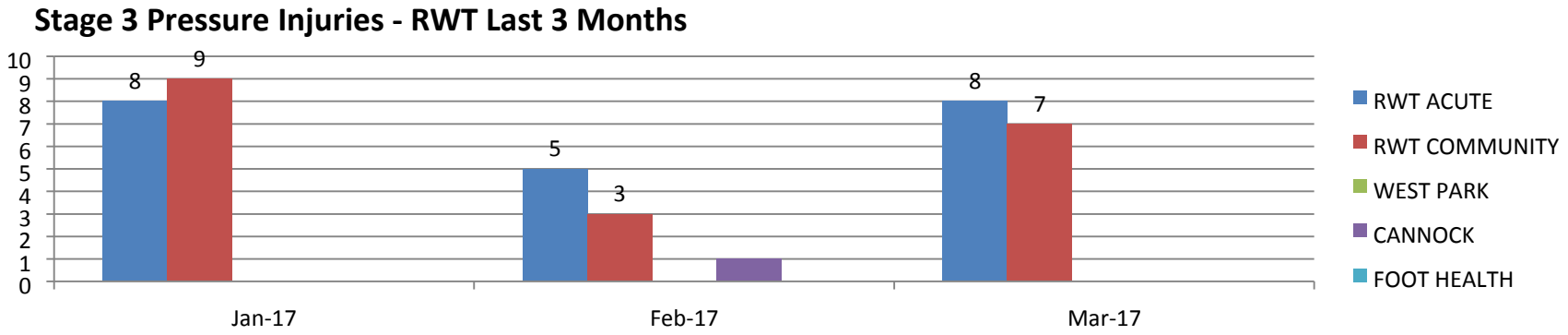
RWT has reported 4 new confirmed Carbapenemase-Producing Enterobacteriaceae (CPE) positive patients during February 2017 (compared to 5 in January 2017). The majority of the February cases were picked up as part of the extensive screening that was carried out following the cluster of cases on the Orthopaedic wards at the end of January. So far there have been 17 new CPE positive patients during 2016/2017. RWT is developing a CPE strategy which includes a business case for molecular testing in the laboratory, full implementation of a risk assessment and screening process, and executive level awareness raising sessions.

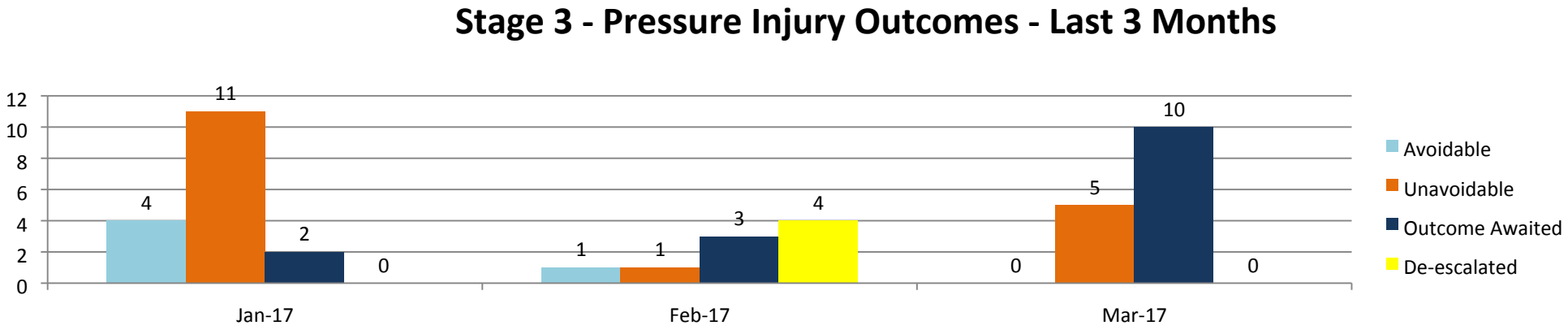
4.1.2 C.Diff Incidence

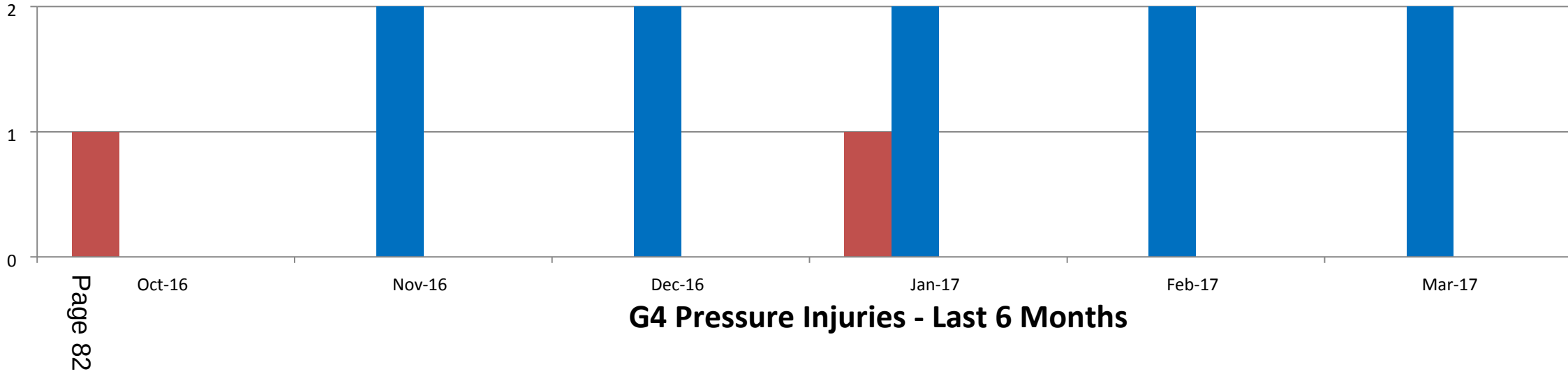
RWT has achieved sustained reduction in CDiff cases for the 6 months. There is only 1 CDiff case attributable to RWT against a target of 2 for the month. RWT is 9 cases over their target at the end of month 11, and have exceeded our external target of 35 cases for the year. However, they have sustained a lower monthly outturn since September which is due to a multimodal strategy, including disposable mop heads and certain antibiotic restrictions



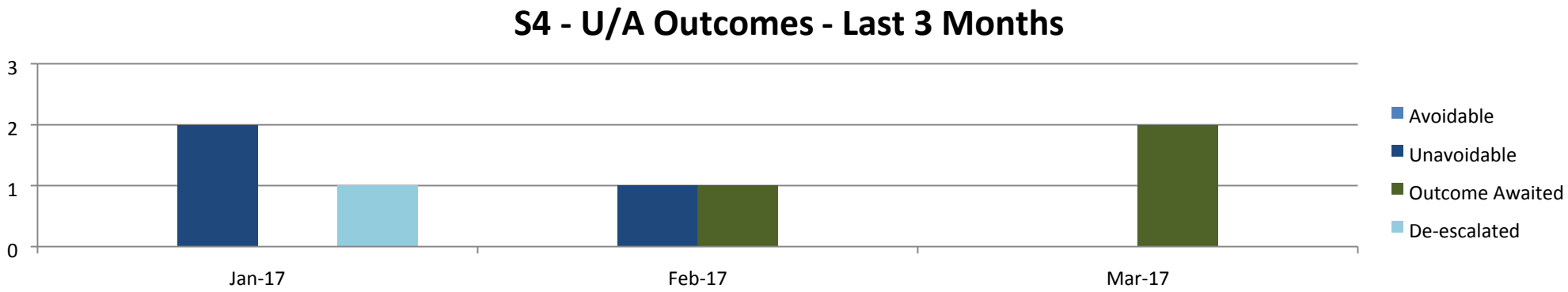
4.1.3 Stage 3 Pressure Injuries, avoidable and unavoidable in the last 3 months







G4 Pressure Injuries - Last 6 Months



There was a total of 17 pressure injury incidents reported for March 2017 which is a significant increase compared to 11 PI's reported in February 2017. There were 15 pressure injuries (Acute 8 + community 7) reported for stage 3 category and 2 stage 4 pressure injury were reported by community. A significant reduction in avoidable pressure injuries has been observed for last 2 months, however, we are continuously monitoring and scrutinising all pressure injuries incidents from the provider. The CCG attends a weekly pressure injury scrutiny meeting at RWT.

The WCCG quality team met with RWT to work collaboratively to develop a city wide pressure injury preventative strategy and to set up a joint pressure injury prevention steering group to plan and deliver this strategy successfully.

RWT pressure injury preventative actions:

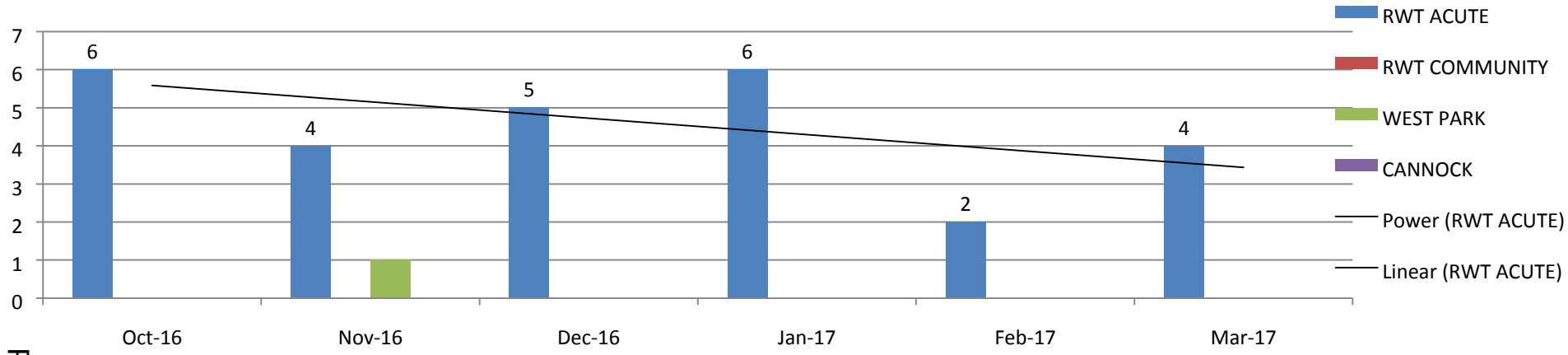
- Tissue Viability Strategy plans for year 1- reviewing the wound formulary as pathway at a time, which leads to further pathway development. Pathways launched with in Trust, General Practices and Nursing Homes.

- Tissue viability steering group and CCG pressure ulcer steering group are working on further analysis of trends and recommended best practice. Some innovations require business cases to support implementation, particularly to prevent inherited incidences.
- CCG are submitting a business case to support a wound centre of excellence in April, with an aim to improve the patient referral and care pathway within a community setting.
- Evaluating a new mattress with improved heel offloading technology in the Northeast locality - evaluation stopped as patient sadly died. No other formal evaluation arranged yet.
- Tabletop exercise to compare heel offloading devices planned for June now once procurement have completed cost analysis the best 3 products, due to plans required for the wound assessment CQUIN.
- To analyse slide sheet orders and compare incidents to agree a standard slide sheet for moving and handling to prevent sheer and friction.
- The Tissue Viability Team have completed a tabletop exercise to agree the skin protectant for the formulary. 2 products were a challenge to choose between with very similar cost savings as well as patient benefits. Therefore a continence exercise was completed by the Lead Nurse. This process confirmed Medihoney barrier cream was best for the patient experience and more work is required on continence advice and management as pads contribute to pressure redistribution. A moisture associated dermatitis prevention pathway will be designed and launched in May 2017.

Tissue Viability Lead Nurse is heavily involved with a task and finish group for NHS improvement for definitions and measurements of pressure injuries. A consensus questionnaire is due to be sent out in April. There will be a national meeting in May 2017. Once analysed, recommendations will be made on how to define a pressure injury/sore/ulcer and what to measure to improve consistency across England.

4.1.4 Patient Slip/Trip/Falls

Slip/Trip/Falls - RWT - Last 6 Months



There were 4 patient falls reported for this reporting period compared to 2 patient falls reported in February 2017.

Themes emerging from Patient Falls RCA's:

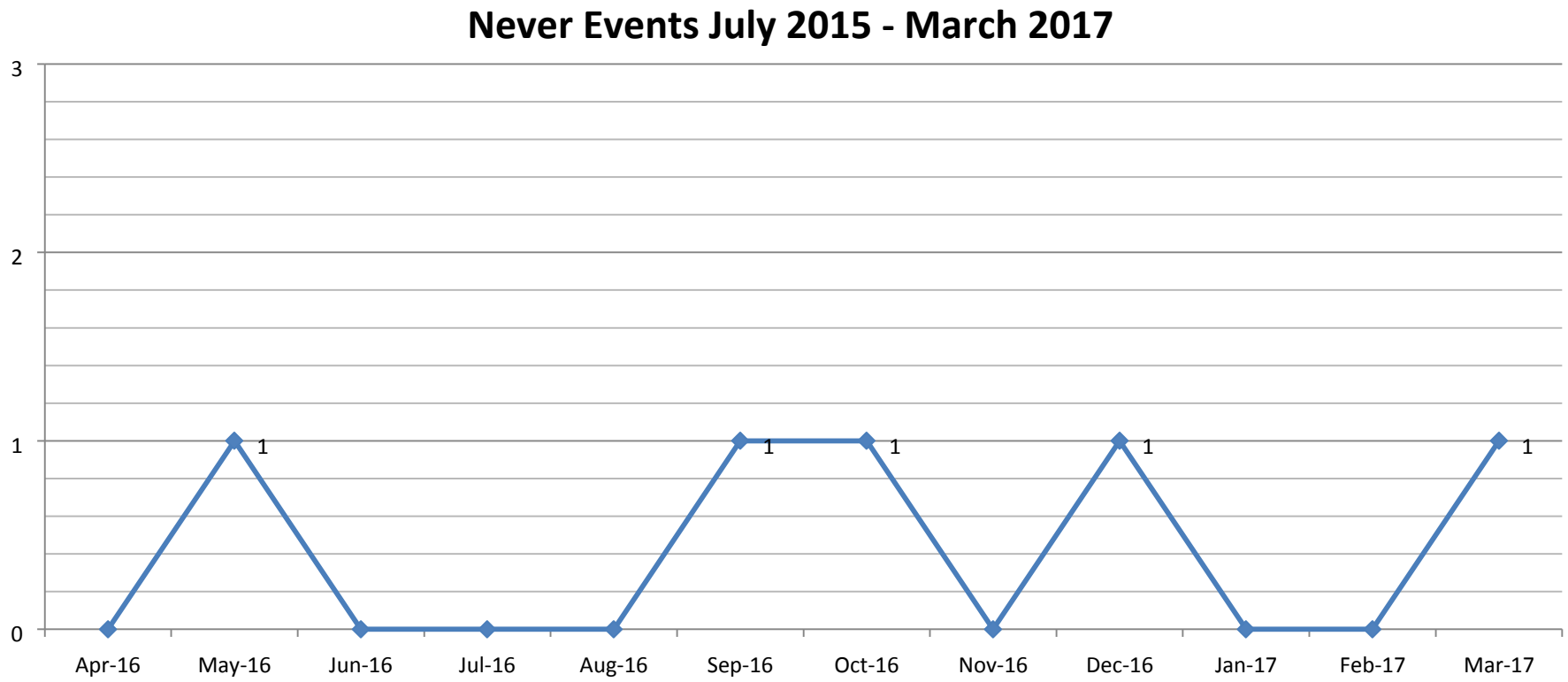
- Delays in patient discharge once medically fit for discharge
- Multiple moves/transfers of patients within hospital
- Patient transfers to inappropriate clinical areas
- Lack of supervision of confused and at high risk of falls patients

Actions:

- Falls prevention and post falls policies has been revised and has been implemented
- Internal and external audits
- Staff training and education

- All clinical staff to ensure medical falls assessment has been completed
- Arm's length and Tag Nursing
- National Falls collaborative project
- Medical training launch for next changeover of trainees

- **5.0 Never Events**



A never event was reported by RWT in March 2017 and this brings the total count to 5 in last 12 months.

6.0 Mortality

RWTs most recent HSMR and SHMI data is indicating deterioration in their position. Whilst some significant targeted work is being carried in in collaboration with the RWT, CCG, NHSi and the CSU, the Trust have commenced on the following actions;

1. Ensure that all directorates follow the mortality policy. That all deaths undergo review that the relevant documentation is forwarded to governance /uploaded onto Sharepoint and any deaths graded as potentially avoidable undergo a formal MDT within the designated timeframe with the summary and actions presented to Mortality Review Group. Managing this process will require directorate and Divisional oversight to ensure that the Trust is compliant, and will be supported by Governance.
2. The Trust has been challenged on the "independence" of the case note reviews and advised that the internal directorate reviews currently give poor external assurance. The Trust is arranging some peer review/audit of case records using clinicians from other Trusts. There is no formal process for arranging this regionally or nationally, so it will need local discussions and arrangements.
3. In addition, it has been recommended that the Trust arrange an external review of clinical "pathways" to provide further assurance that these are robust and safe and are not exposing gaps which could cause adverse outcomes. The Trust will review Myocardial Infarction and UGI haemorrhage pathways (these are diagnostic groups which are currently alerting).
4. The Trust will also review their process for palliative care coding. The Trust is suggesting that this has progressively declined since the introduction of the Swan project, perhaps to the detriment of the HSMR, but not so much to the SHMI. Interestingly, in Salford (where the Swan project was developed) their palliative care coding remains high as a percentage.
5. The Trust will need to review notes documentation and coding/ capture of co-morbidities and also review the data submissions more generally compared to peer Trusts. Currently this is being considered.
6. A more comprehensive report is being collated, awaiting business intelligence data from CSU.

Update from RWT Mortality Board papers include the following actions agreed March 2017:

- A senior external clinical review of clinical pathways within the organisation. This will be organised shortly, terms of reference are in process of being set out and will be overseen and approved by the executive mortality assurance group.
- An external peer review of deceased patients' case notes, focused on a selection of diagnosis groups that have had a raised SMR and have been reviewed internally.
- External review of data and clinical coding by an independent reviewing organisation with expertise and experience in managing data sets and clinical coding.
- Engaging with CSU to draw on their expertise of working with other trusts on similar issues and explore potential causes for diagnosis level raised SMRs.
- A review of palliative care and end of life care coding to include a review of practices in England in order to aid understanding of the wide variation across England.
- Review and improve plan of consultants and clinical coders working together to improve accuracy of coding.
- Escalation of the elevated SHMI and HSMR to the Trust's risk registers. Update provided to the Trust Board for discussion.

7.0 Items to Note from CQR Meeting - March 2017

- Cancer Waiting Times/Cancer Target Compliance

	Target	Q3 2016/17				Q4 2016/17			
		Oct-16	Nov-16	Dec-16		Jan-17	Feb-17	Mar-17	Feb-17
2 Week Wait Cancer	93%	93.02%	93.42%	94.56%		95.51%	93.35%		Excluding Tertiary Referrals
2WW Breast Symptomatic	93%	94.02%	95.89%	99.46%		99.44%	93.20%		
31 Day to First Treatment	96%	96.55%	94.55%	98.48%		97.49%	96.13%		
31 Day Sub Treatment - Anti Cancer Drug	98%	100.00%	98.53%	100.00%		100.00%	100.00%		
31 Day Sub Treatment - Surgery	94%	93.62%	82.00%	78.38%		71.43%	76.67%		
31 Day Sub Treatment - Radiotherapy	94%	94.66%	100.00%	100.00%		97.52%	97.73%		
62 Day Wait for First Treatment	85%	70.66%	69.02%	80.00%		73.08%	77.98%		81.94%
62 Day Wait - Screening	90%	80.00%	95.83%	90.48%		88.89%	66.67%		70.00%
62 Day Wait - Consultant Upgrade (local target)	88%	90.78%	90.00%	90.51%		92.54%	94.92%		98.15%

31 Day Sub Surgery - 7 patient breaches during the month, all of these were Urology patients that we were unable to schedule within standard (7 of these were patients waiting for robotic surgery).

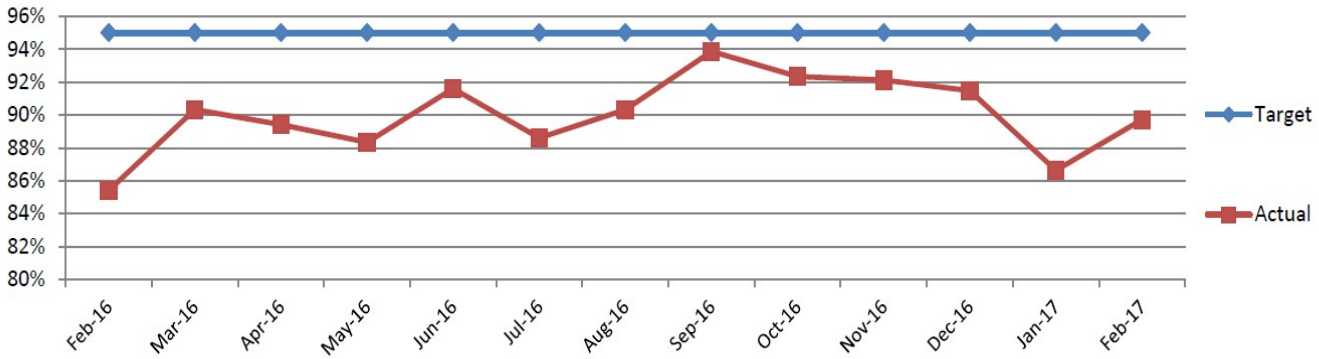
62 Day Traditional - 24 patient breaches in month - 11 x Tertiary referrals received between days 41 and 82 of the patients pathway (operating guidelines state referrals should be made within 42 days), 6 x Capacity Issues, 1 x Patient Initiated and 6 x Complex Pathways. Of the tertiary referrals received in month 8 (72.7%) were received after day 42 of the pathway, and 2 (18.2%) were received after day 62 of the patient pathway.

62 Day Screening - 4 patient breaches - 3 x patient initiated and 1 x further investigations required.

- A&E Performance

Total Time Spent in Emergency Department (4 hours)

		Q3 2016/17				Q4 2016/17		
	Target	Oct-16	Nov-16	Dec-16		Jan-17	Feb-17	Mar-17
New Cross	95%	86.78%	86.19%	84.91%		77.44%	82.75%	
Walk in Centre		100.00%	100.00%	100.00%		100.00%	100.00%	
Cannock MIU		100.00%	100.00%	100.00%		100.00%	100.00%	
Vocare		99.61%	99.27%	98.11%		97.24%	96.00%	
Combined		92.33%	92.12%	91.47%		86.63%	89.71%	



- Ambulance Handover

	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Number between 30-60 mins	0	53	60	53	87	50	50	44	30	105	221	146	
Number over 60 minutes	0	0	5	3	5	6	0	53	4	17	41	37	

Ambulance handover saw an improvement in month for both 30-60 minutes and the >60 minute handover target. The sanction for Ambulances during February was £66,200. This is based on 146 patients between 30-60 minutes @ £200 per patient and 37 patients >60 minutes @ £1,000 per patient.

8.0 Health and Safety

As reported in February, the actions identified by the Fire Inspection have now been completed and all documentation has been received by the CCG. Q4 report will be presented to SMT/QSC in April 2017 and assurance summary provided for the Governing Body.

9.0 EDS2 Compliance

A separate report has been presented to Governing Body on 14th March 2017, with full assurance of compliance to the EDS2 requirements. The Governing Body will be requested to note and sign off the work for publication by 31st March 2017.

10.0 BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST

The Governing Body is asked to note the following:

Serious Incidents
There were 2 serious incident reported for March 2017 for BCPFT.

These relate to a treatment delay and apparent/actual/suspected self-inflicted harm meeting SI criteria.

Pressure Injury SI update: pressure injury serious incident reported in May 2016 this incident still remains open on the STEIS because WCCG has challenged the outcome of this pressure injury incident as "Unavoidable" by BCPFT. This PI has been discussed by WCCCG Executive Nurse Lead and BCPFT Director of Nursing. The CCG still need to see a final RCA and action plan. This pressure injury SI will remain deferred until we receive the full and final RCA from BCPFT.

10.1 CQC Report – the Trust has now received the final report from the CQC following last year's inspection. The Trust has been rated as "good" overall which is an improvement on the previous rating. A congratulations letter has been sent to BCPT CEO and Chairman from Dr Dan De Rosa.

11.0 OTHER PROVIDERS

11.1 Vocare (Out of Hours)

There were 3 serious incidents reported in this reporting period and all these incidents relate to treatment delays. Vocare is investigating these incidents internally and we are waiting for the final RCA submission from the provider. CQC has visited the Urgent Care Centre on 24th March 2017.

Actions:

- Continuous monitoring of these issues through monthly CQRM's
- Robust scrutiny of all SI's received
- Planned data verification with clinical input on 6th April 2017
- Work collaboratively with CQC
- Issue letter of concern regarding quality requirements
- Board to Board meeting
- Improvement Board meeting to be held April 2017

12.0 CHILDREN'S SAFEGUARDING

a) OFSTED

The judgement of the recent Ofsted inspection of Children's Services in the City of Wolverhampton was published on 31.3.17. The Overall Judgement is Good.

This Good judgement places the City of Wolverhampton within the top 20% of councils nationally, and joint 23rd out of the 129 councils to have been inspected under the current framework –there are only two "Outstanding" councils in the whole of the country putting this achievement into context.

b) CQC

Following the publication of the CQC report of its review of health services relating to safeguarding children and services for looked after children in Wolverhampton, WCCG have developed and submitted an action plan as required, to address the recommendations. This will be monitored by WCCG through a Strategic Group and CQC colleagues in the Central Region, who will determine the appropriate regulatory response.

c) MASH

The WCCG Safeguarding Children Administration Officers have now commenced in post. There has been some initial feedback and thanks from the Senior Social work manager MASH as there has some very positive feedback regarding the checks completed by one of the officers in the absence of the MASH Nurses , stating they were all in timescales and very relevant. It is clear that despite that the role is still developing, it is already making a difference in ensuring relevant and appropriate information is available to support the assessment of risk following a referral into the MASH.

d) Safeguarding Quality Visit

A number of WCCG Safeguarding Team, supported by the Regional Prevent Lead carried out a Quality Safeguarding Visit to BCPFT.
The Purpose of the visit was to observe how the service is provided as per set rationale, to gather evidence to support each area and ask any questions deemed appropriate in determining the level of assurance the evidence affords.

WCCG was keen to acknowledge the volume of information that had been made available since the visit was initially arranged for July 2016. This included:

- The CQC review of health services for Children Looked After and Safeguarding in Wolverhampton Recent report published by CQC
  Completion of the joint safeguarding dashboard
- Presentation of two reports in line with the assurance/reporting framework

As a result, the visit was a targeted visit to gain assurances for specific areas where further clarity or evidence was required to ensure WCCG is assured that BCPFT have safe and effective safeguarding arrangements in place.

Initial verbal feedback was provided at the time of the visit with a draft report sent to the organisation for comments on factual accuracy prior to a final report being agreed.

12.1 Adult Safeguarding

a) Care Homes

Four pressure injuries were reported requiring RCA investigation reported in care homes during March, the same as the previous month. All RCA investigations are scheduled to be presented at CCG Pressure Injury Scrutiny Group during Quarter 1.

The QNAT received 11 safeguarding referrals. Three required Adult MASH discussions, 2 of the 3 required Section 42 investigations. Five new SI's, all of which were falls with fractures and this was up on previous months when 2 were reported. More detailed analysis of falls with fractures will be completed to determine root causes and the development of a prevention plan by the end of Quarter 1.

b) Probert Court

Probert Court is currently working on a robust action plan to improve the medicine management practice and is closely monitored and supported by WCCG's Quality Team.

Issues identified through Probert Court CQRM's:

- Meds safety at Probert court
- Mandatory and statutory training compliance
- Poor Safety thermometer compliance
- Safeguarding training

WCCG Actions:

- Monitor through CQRM's
- Regular Quality visits and support by quality team
- Issue letter of concern regarding quality requirements

It should be noted that from 1st April 2017 Probert Court will be managed by Accord Housing Association Limited.

13.0. Improving Quality in Primary Care

As of 1st April 2017, the CCG will be fully delegated for Primary Care Commissioning. In preparation for this, the Quality Team have met with NHSE colleagues to ascertain the handover. A full handover for Quality is planned for March 20th (both Directors of Nursing from CCG and NHSE). The Quality Team are also reviewing what impact this will have on team resource and capacity. This will be kept under review for the first few months to monitor.

13.1 Workforce

The workforce fair is still in the final planning phase with a tentative date of late May/early June 2017.

GPFV programmes including administrator training and practice manager development have commenced.

Root Cause Analysis training is being held on 10th March and 6th April for practice staff involved in investigating serious incidents/significant events.

Work around training and workforce analysis for the PCH and VI practices is being planned for April.

Risks around changes to the nursing associate placements have been identified and will be added to the Workforce risk register.

13.2 Infection Prevention.

No reports have been received this month – the IP audit process will commence again in April 2017 for the next financial year.

IP Audit Ratings: Gold 97-100%; Silver 91-96%; Bronze 85-90%

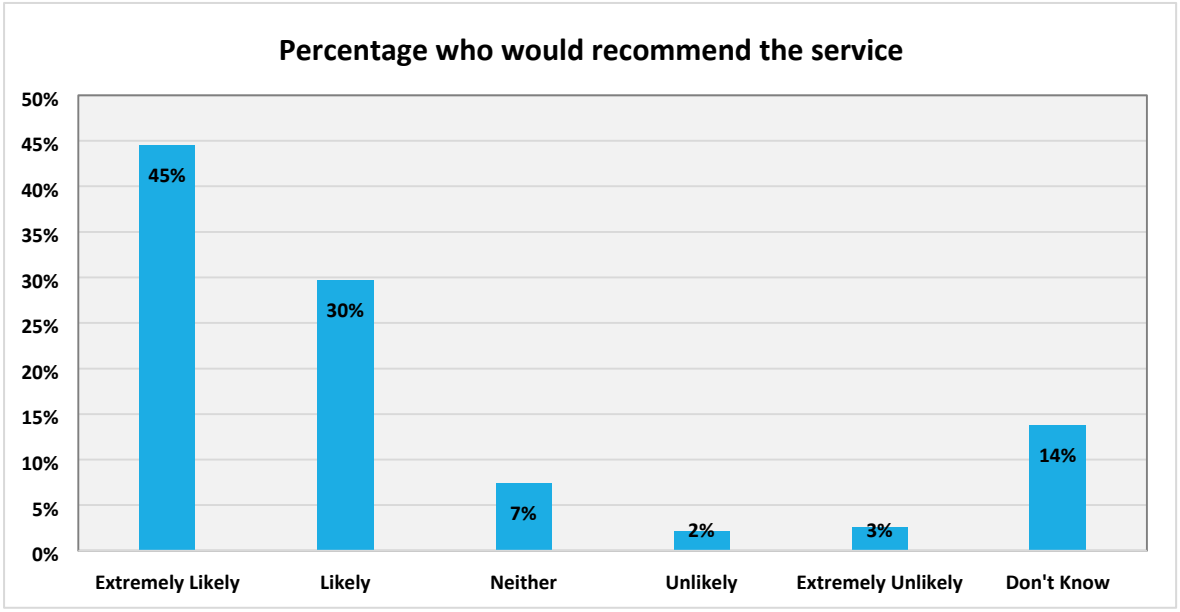
0 MRSA bacteraemia attributed to WCCG in year to date.

13.3 Friends & Family Test

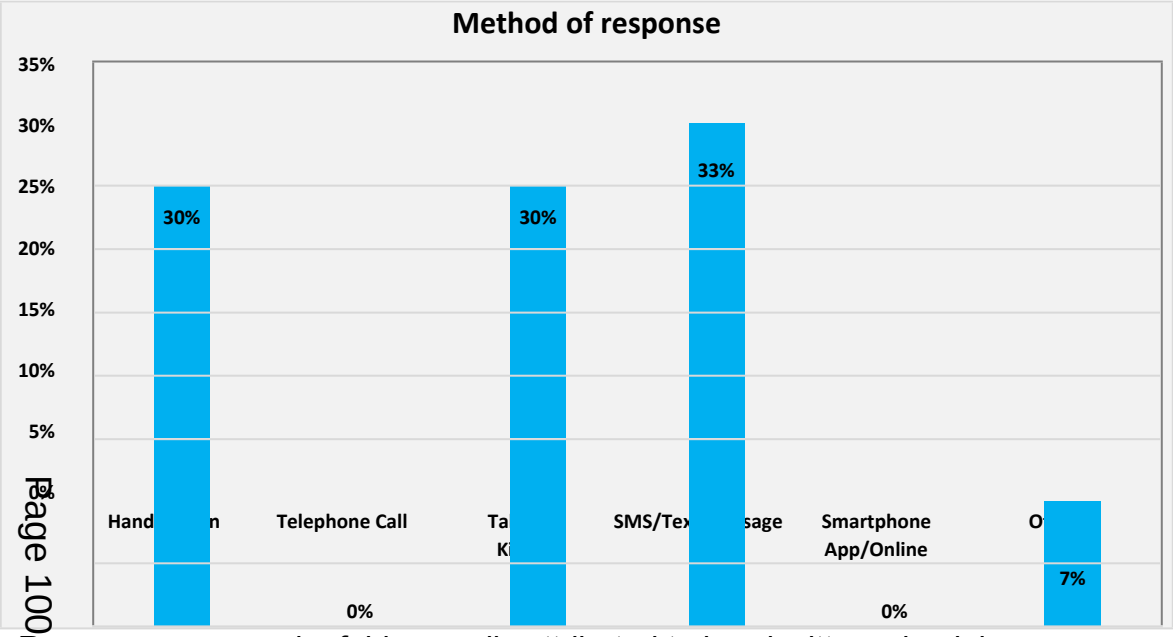
Data:

GP FFT	Submission for - March 2016 (January Data)		
	WCCG	West Mids	England
Percentage Recommended	74% ⇩	87% ⇩	89% ⇔
Percentage Not recommended	5% ⇧	6% ⇔	6% ⇔
No of Practices "no data"	11		
No of Practices had data suppressed *(returns with less than 5 responses are not included in the final analysis by NHSE)*	7		
No of practices with 0 responses	4		

The recommended rate from previous months has gone down to 74% from 84% and the percentage not recommended has gone up to 5% from 4% from the previous month.

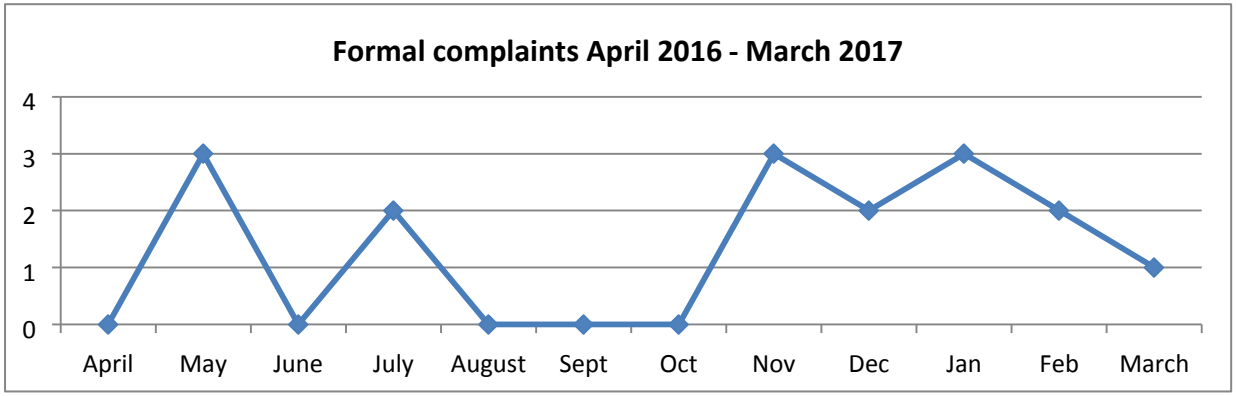


The 75% of responses were positive (extremely likely or likely), 10 practices had responses that included unlikely or extremely unlikely to recommend which is down on 18 last month. Of these practices this ranged from 2% – 16% of their overall responses, however response numbers were low again for some sites and this has skewed the figures. Overall 21% of respondents also gave a neither or don't know answer to this question which is an increase from 12% last month, again figures are low and it is difficult to draw conclusions.



Responses are again, fairly equally attributed to handwritten, check in screens and SMS indicating that the use of technology does help to improve uptake, but “traditional” methods are also key. Work continues with Sheila Gregory and a social media campaign to increase activity e.g. via check in screens, web sites, text etc., methods to increase FFT submission via the PPG were discussed by Sarah Southall and Liz Corrigan at the PPG Chairs meeting on 21st March.

14.0 Formal complaints



A complaint received by WCCG which had been closed is now being investigated by the Parliamentary and Health Service Ombudsman. The outcome of which will be reported accordingly.

15. BOARD ASSURANCE FRAMEWORK/RISK REGISTER

4th April 2017	TOTAL
Open Risks	79
Extreme	6
High	41
Moderate	30
Low	2

The Quality Assurance Co-ordinator is currently working on a draft template that will be presented to the Governing Body and individual Committees for assurance, regarding the management of risks in each Committee portfolio.

The QAC is pursuing webinar opportunities with Datix to ascertain if adding their Dashboard module to the CCG's existing Datix system would give the trend line that is required. Should this be possible, there would be a cost implication. The alternative is for the CCG's Business Information Team to look at ways of improving current Committee reports to include a trend line, which is currently a manual task and would prove to be very time consuming.

It is planned to share an update in May.

16.0 RECOMMENDATIONS For **Assurance**

- **Note** the actions being taken.
- **Note** the actions taken to address RWT Mortality Alert
  Note OFSTED good Inspection.
- **Note** the contractual action taken with Vocare
- **Note** The Never Event at RWT
- **Continue** to receive monthly assurance reports

Name: **Steve Forsyth Job Title: Head of Quality & Risk Date:** **4th April 2017**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
11th April 2017

Agenda item 13

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 11th April 2017**
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.
Recommendations:	• **Receive** and **note** the information provided in this report.
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	£351.567m	£351.567m	Nil	**G**
Revenue Administration Resource not exceeded	£5.555m	£5.505m	£0.050m	**G**

Non Statuory Duties	YTD Target	YTD Actual	Variance o(u)	RAG
Maximum closing cash balance £'000	291	43	(248)	G
Maximum closing cash balance %	1.25%	0.18%	-1.13%	G
BPPC NHS by No. Invoices (cum)	95%	99%	-4%	G
BPPC non NHS by No. Invoices (cum)	95%	95%	0%	A
QIPP	£10.21m	£8.34m	£1.87m	A
Programme Cost £'000*	305,454	306,966	1,512	G
Reserves £'000*	1,631	0	(1,631)	G
Running Cost £'000*	5,092	5,042	(50)	G
BPPC NHS by Value (cum)	95%	100%	-5%	G
BPPC non NHS by Value (cum)	95%	97%	-2%	G

- The net effect of the three identified lines (*) is a small under spend. The CCG anticipates delivering breakeven by the end of the financial year.
- Forecasting to deliver target surplus at year end (£6.172m).
- The utilisation of the Contingency Reserve is required to achieve the target position leaving little cover for any deterioration in position.
- 1.7% underlying recurrent position is achieved

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

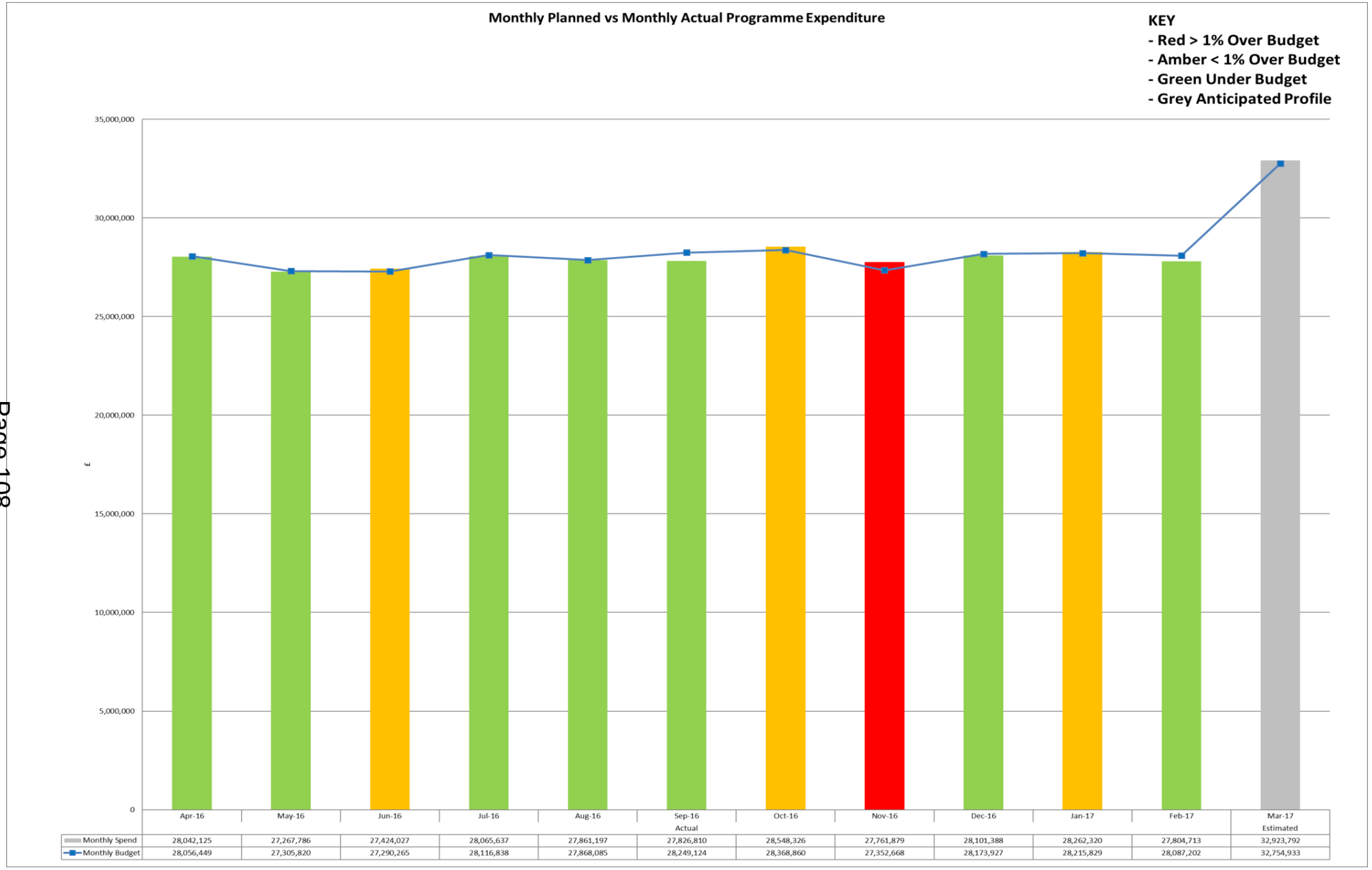
- The table below assumes that the 1% reserve will be fully committed.
- At M11 the non-recurrent allocation relates to central allocations from NHSE to support the wider Black Country Health Economy therefore the CCG is not able to commit this resource.
- NHSE has now issued guidance as to the treatment of the 1% Reserve as part of the national system-wide risk management plan and states
  "..provider financial position is such that we [NHSE] now require each commissioning organisation to release the full amount of the 1% non-recurrent reserve to its bottom line."
- Guidance was issued on 15th March(Appendix 7) and now requires CCGs in month 12 reporting to increase their planned surplus by the value of the 1% reserve. The CCG will have delivered £6.979m with is £0.807m over target plus £3.375m being the release of the 1% reserve.

	Annual Recurrent £'000	Annual Non Recurrent £'000	Total £'000	Yr End Variance Recurrent £'000	Yr End Variance Non Recurrent £'000	Total £'000
Contingency Reserve	1,780	0	1,780	(1,780)	0	(1,780)
1% Reserve	3,375	807	4,182	0	0	0
Total	**5,154**	**807**	**5,961**	**(1,780)**	**0**	**(1,780)**

	Annual Plan £'000	YTD Performance M11			
		Plan £'000	Actual £'000	Variance £'000 o(u)	Var % o(u)
Acute Services	180,900	165,398	169,051	3,653	2.2%
Mental Health Services	34,686	31,795	31,744	(52)	(0.2%)
Community Services	37,682	34,545	33,495	(1,050)	(3.0%)
Continuing Care/FNC	12,259	11,237	12,207	970	8.6%
Prescribing & Quality	51,744	47,392	45,967	(1,425)	(3.0%)
Other Programme	16,608	15,087	14,502	(584)	(3.9%)
Total Programme	**333,879**	**305,454**	**306,966**	**1,512**	**0.5%**
Running Costs	5,555	5,092	5,042	(50)	(1.0%)
Reserves	5,961	1,631	0	(1,631)	(100.0%)
Total Mandate	**345,395**	**312,177**	**312,008**	**(169)**	(0.1%)
Target Surplus	6,172	5,660	0	(5,660)	(100.0%)
Total	**351,567**	**317,837**	**312,008**	**(5,829)**	(1.8%)

The table below details the forecast out turn by service line at Month 11.

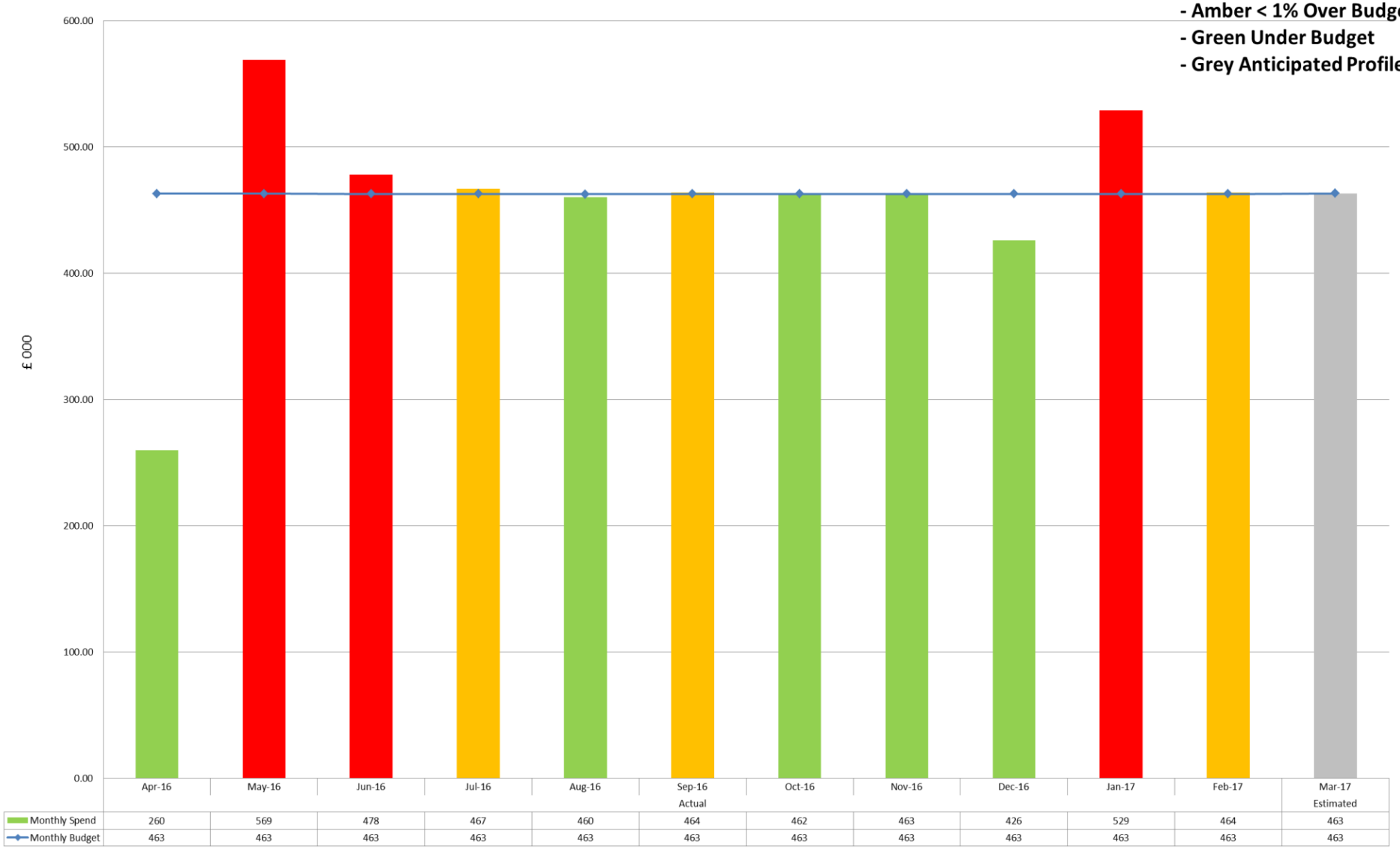
	Annual Plan £'000	Yr End Forecast £'000	Yr End Variance Total £'000 o(u)	Yr End Variance Recurrent £'000 o(u)	Yr End Variance Non Recurrent £'000 o(u)	Yr End Variance %
Acute Services	180,900	184,760	3,860	2,515	1,345	2.13%
Mental Health Services	34,686	34,709	23	399	(376)	0.07%
Community Services	37,682	36,572	(1,110)	(1,596)	486	(2.95%)
Continuing Care/FNC	12,259	13,601	1,343	1,194	149	10.95%
Prescribing & Quality	51,744	49,986	(1,758)	(1,835)	77	(3.40%)
Other Programme	16,608	16,080	(528)	1,102	(1,631)	(3.18%)
Total Programme	**333,879**	**335,708**	**1,830**	**1,780**	**50**	**0.55%**
Running Costs	5,555	5,505	(50)	0	(50)	(0.90%)
Reserves	5,961	4,182	(1,780)	(1,780)	0	(29.85%)
Total Mandate	**345,395**	**345,395**	**(0)**	**(0)**	**0**	**(0.00%)**
Target Surplus	6,172	0	(6,172)	0	(6,172)	(100.00%)
Total	**351,567**	**345,395**	**(6,172)**	**(0)**	**(6,172)**	**(1.76%)**



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16 Actual	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17 Estimated
Monthly Spend	28,042,125	27,267,786	27,424,027	28,065,637	27,861,197	27,826,810	28,548,326	27,761,879	28,101,388	28,262,320	27,804,713	32,923,792
Monthly Budget	28,056,449	27,305,820	27,290,265	28,116,838	27,868,085	28,249,124	28,368,860	27,352,668	28,173,927	28,215,829	28,087,202	32,754,933

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



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16 Actual	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17 Estimated
Monthly Spend	260	569	478	467	460	464	462	463	426	529	464	463
Monthly Budget	463	463	463	463	463	463	463	463	463	463	463	463

2. QIPP

The Committee noted a small improvement in the QIPP Programme FOT as at Month 11.

The key points to note are as follows:

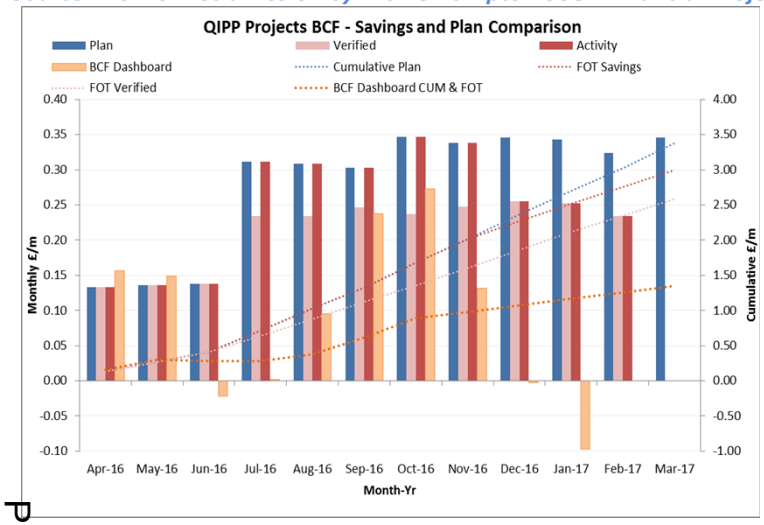
- The financial position of the CCG is predicated on achieving 100% of QIPP.
- The CCG is experiencing overperformance in areas where QIPP has been removed from contracts but schemes are not taking the desired levels of activity out e.g. BCF, as identified between reported and verified QIPP.
- There are no plans to achieve the residual unallocated QIPP, the majority of which is in relation to BCF Stretch, therefore the financial impact has been incorporated into the FOT.
- 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.

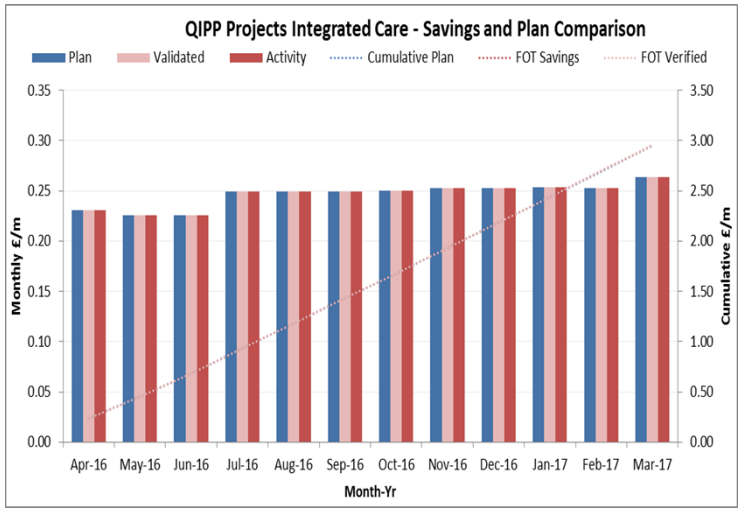
QIPP Programme Delivery Board - Validated Figures for Non ISFE

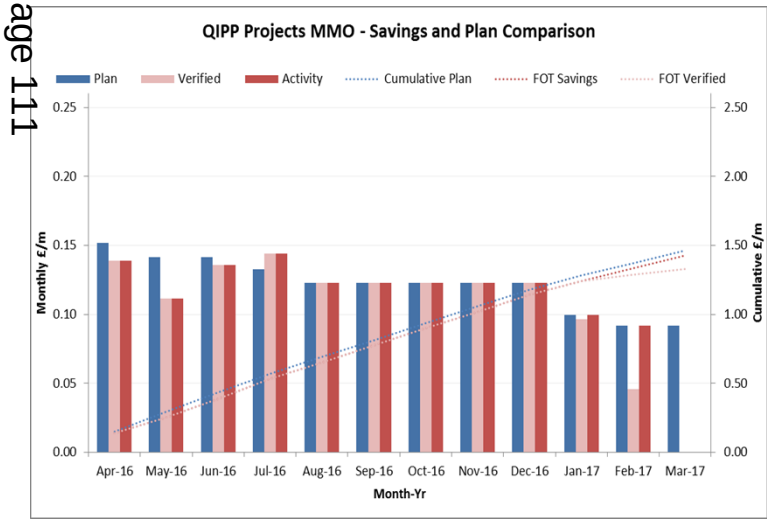
Reporting Period : Feb-17

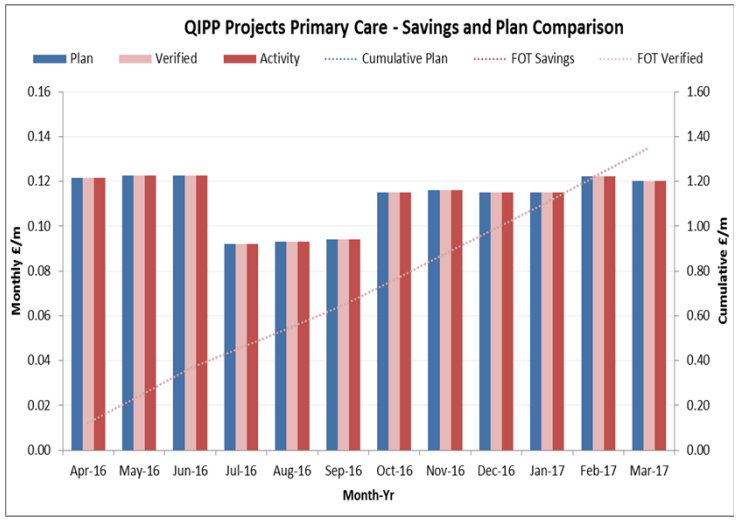
Financial Savings Projects within QIPP Programme Delivery Board and Annual Plan

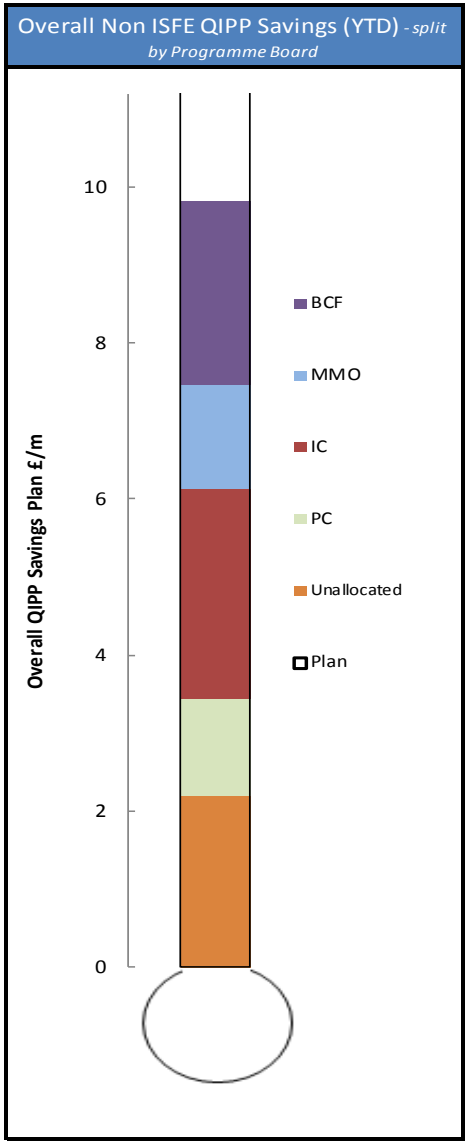
Source : Non ISFE Submission by Wolverhampton CCG - Financial Projects Only & BCF Dashboard









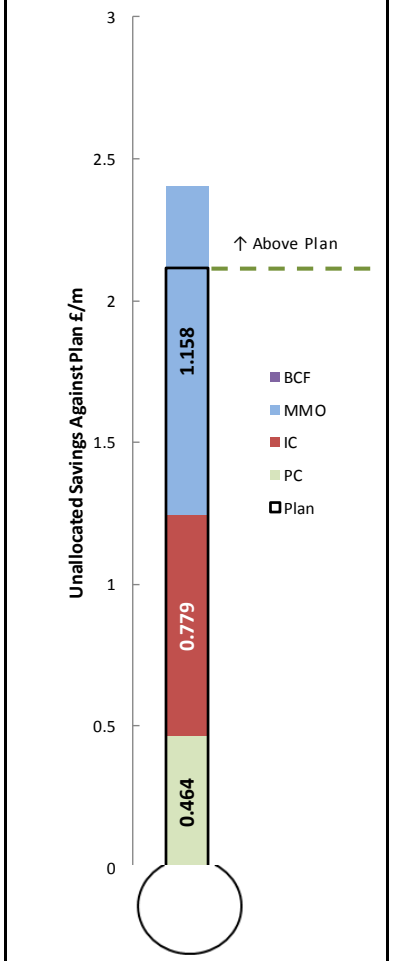


Note : Cumulative figures are based on a secondary axis

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

Project Ref	Project Description	M11 Plan (YTD)	M11 Non ISFE (YTD)	M11 Variance From Plan	Annual Plan (FOT)	M11 Non ISFE FOT	FOT Variance from Plan	M11 YTD Non ISFE diff from Prog Brd	M11 FOT Non ISFE diff from Prog Brd
FRP4	Primary Care In reach Teams (PITs) Model of Care	-0.25	-0.25	0.00	-0.28	-0.28	0.00	0.00	0.00
FRP12	Asthma Avoidable Admissions	-0.09	-0.09	0.00	-0.10	-0.10	0.00	0.00	0.00
FRP13	Chronic Obstructive Pulmonary Disease (COPD) review	-0.08	-0.08	0.00	-0.09	-0.09	0.00	0.00	0.00
FRP14	**UC Centre Procurement**	**1.19**	**1.19**	**0.00**	**1.32**	**1.32**	**0.00**	**0.00**	**0.00**
FRP14a	OOH - UCC Scheme	1.61	1.61	0.00	1.76	1.76	0.00	0.00	0.00
FRP14b	EAU - UCC (Acute Contracts - NHS (incl Ambulance Service)	0.62	0.62	0.00	0.68	0.68	0.00	0.00	0.00
FRP14c	UCC - (Acute Contracts - NHS (incl Ambulance Service)	1.25	1.25	0.00	1.38	1.38	0.00	0.00	0.00
FRP14d	UCC - (Other Programme Services) - Investment	-2.29	-2.29	0.00	-2.50	-2.50	0.00	0.00	0.00
FRP18	Interpreting Contract	0.06	0.06	0.00	0.07	0.07	0.00	0.00	0.00
FRP20	Maternity Pathway Review & ad hoc contract lines	0.39	0.39	0.00	0.43	0.43	0.00	0.00	0.00
FRP30	Products Containing Glucosamine	0.04	0.00	-0.04	0.04	0.00	-0.04	0.000	0.000
FRP31	Prescribing Internal Efficiencies	0.81	0.81	0.00	0.86	0.86	0.00	0.00	0.000
FRP35	Community Ultrasound (Diagnostic Health) (Post ERG)	0.01	0.01	0.00	0.01	0.01	0.00	0.00	0.00
FRP36	PUVA/B tariff	0.23	0.23	0.00	0.25	0.25	0.00	0.00	0.00
FRP37	**MSK Procurement (Savings)**	**0.01**	**0.01**	**0.00**	**0.01**	**0.01**	**0.00**	**0.00**	**0.00**
FRP37a	Independent Physio MSK	0.01	0.01	0.00	0.02	0.02	0.00	0.00	0.00
FRP37b	Community Physio MSK	0.09	0.09	0.00	0.14	0.14	0.00	0.00	0.00
FRP37c	Acute Physio / T&O MSK	0.10	0.10	0.00	0.15	0.15	0.00	0.00	0.00
FRP37d	OCAS MSK	0.05	0.05	0.00	0.08	0.08	0.00	0.00	0.00
FRP37e	MSK Investment	-0.25	-0.25	0.00	-0.37	-0.37	0.00	0.00	0.00
FRP38	PEARS	0.28	0.28	0.00	0.30	0.30	0.00	0.00	0.00
FRP41	Respiratory in A&E/AMU	0.49	0.49	0.00	0.54	0.54	0.00	0.00	0.00
FRP49	Mental Health ICS	0.23	0.23	0.00	0.25	0.25	0.00	0.00	0.00
FRP51b	RWT EOL SDIP	0.18	0.18	0.00	0.20	0.20	0.00	0.00	0.00
FRP54	Therapy Service Review (R+R TEAM RWT)	0.19	0.19	0.00	0.21	0.21	0.00	0.00	0.00
FRP55	WVSC Grant Payment	0.07	0.07	0.00	0.07	0.07	0.00	0.00	0.00
FRP56	Age Uk Supportive discharge (Post ERG)	0.01	0.01	0.00	0.02	0.02	0.00	0.00	0.00
FRP58	CHC Adults	0.14	0.14	0.00	0.15	0.15	0.00	0.00	0.00
FRP59	EPP (Specific Client)	0.17	0.17	0.00	0.18	0.18	0.00	0.00	0.00
FRP62	Closed List LD	0.13	0.13	0.00	0.14	0.14	0.00	0.00	0.00
FRP63	Heatun Transactional Costing	1.10	1.10	0.00	1.20	1.20	0.00	0.00	0.00
FRP65	**BCF 2016/17 Savings**	**2.95**	**2.27**	**-0.68**	**3.29**	**2.50**	**-0.79**	**-0.68**	**-0.79**
FRP65a	BCF 2016/17 Savings (banked)	2.27	2.27	0.00	2.50	2.50	0.00	0.00	0.00
FRP65b	BCF 2016/17 Savings (stretch)	0.68	0.00	-0.68	0.79	0.00	-0.79	-0.409	-0.409
FRP76	WUCTAS Decommissioning of the Medical Triage Service	0.08	0.08	0.00	0.09	0.09	0.00	0.00	0.00
FRP78	Unallocated Savings 2016/17	1.88	2.21	0.32	2.12	2.40	0.28	1.46	0.00
	Other								
	Grand Total	10.20	9.81	-0.39	11.26	10.72	-0.54	1.054	-0.409

New Schemes To Address Unallocated Savings (FRP78) FOT Thermometer - *split by Programme Board*



Key:

Modernisation and Medicines Optimisation	Better Care Fund
Integrated Care	Unallocated
Primary Care	*Closed (project reference only)*
Top-line Total - see individual split	

3. PERFORMANCE

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

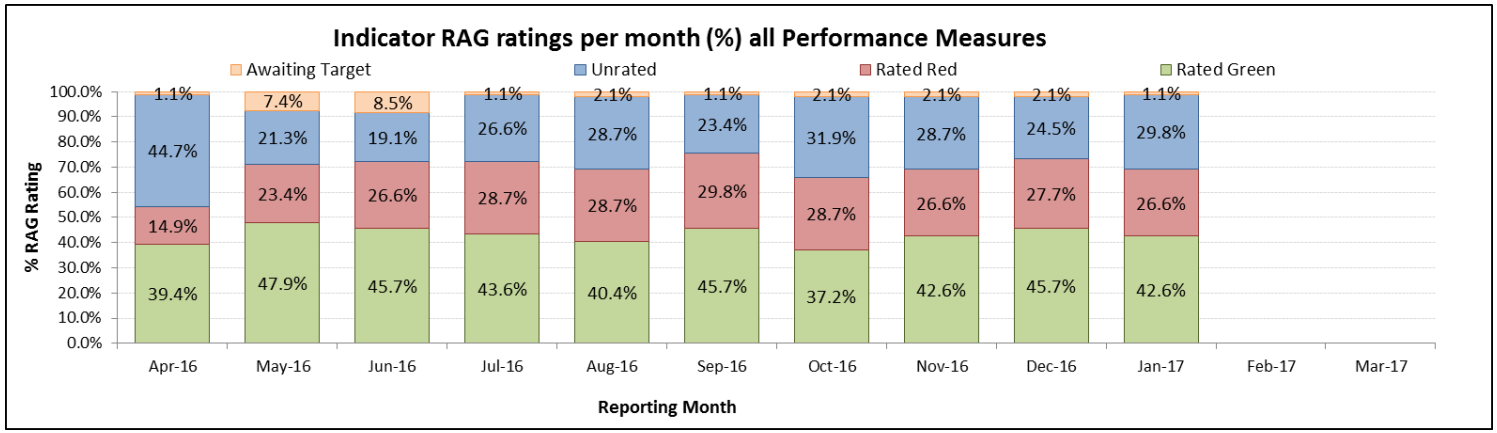
Executive Summary - Overview

Jan-17

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	No Submission (blank)	Previous Mth	Target TBC *	Total
NHS Constitution	11	9	11	11	2	4	0	0	**24**
Outcomes Framework	10	9	8	7	17	20	2	1	**37**
Mental Health	22	22	7	7	4	4	0	0	**33**
Totals	**43**	**40**	**26**	**25**	**23**	**28**	**2**	**1**	**94**

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	No Submission (blank)	Previous Mth:	Target TBC *
NHS Constitution	46%	38%	46%	46%	8%	17%	0%	0%
Outcomes Framework	27%	24%	22%	19%	46%	54%	5%	3%
Mental Health	67%	67%	21%	21%	12%	12%	0%	0%
Totals	**46%**	**43%**	**28%**	**27%**	**24%**	**30%**	**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 January 17)



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%	91.22%	90.30%	91.08%	90.11%				90.87%	92.00%

The performance data for headline level RTT (Incompletes) has not been submitted as part of the January report. At time of submission the Trust confirmed that "Data was not available at time of submission" and have since confirmed performance as 90.59% and below the 92% target. The January data has since been validated via the National Unify2 submission as 90.59% with 2,929 (out of 31,110) waiting more than 18 weeks. When compared to the previous years performance, there has been a decrease in compliance (Jan 15/16 = 92.03% - 2425 breaches out of 30415, Jan 16/17 = 90.59% - 2929 breaches out of 31110) and an overall increase in the number of patients on the waiting of 695 (2.29% increase). Work on the Demand Management Plan (DMP) continues with data so far (up to December 16) exceeding targets despite the impact of the winter pressures and holiday season. Following the identification of over 100 Hernia and Laparoscopic Cholecystectomy patients for potential diversion to the Independent Sector, it has been confirmed that only 1 patient is suitable for diversion due to the complexity of those awaiting treatments, however the CCG expects the patient to be diverted imminently. The CCG have requested the waiting list numbers for varicose vein patients that could also benefit from the referral diversion process and are awaiting the data to assess if any can be progressed before the end of March. The Trust have confirmed that 100 staff have received training to ensure that all RTT pathways are validated from the start of the patients journey and although this is a positive step for referred patients, it has lowered the performance denominator (the total number of patients on the waiting list) and therefore the overall compliance percentage. RTT performance (including 52 Week Waiters and Referral Diversions) continues to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. The CRM meeting during February discussed the January performance as 90.59% with an expected compliance recovery by Quarter 1 of 2017/18. The Trust confirmed provisional performance data for February as part of the NHS England Assurance Call as 90.5% and remains below the STF and National target. The Trust have confirmed that they expect the number of Orthodontic patients waiting over 52 weeks to rise in February due to the consultant for Orthodontics annual leave during the month, however have planned for remaining patients waiting to be within the low teens and ahead of the local recovery trajectory for March 2017.

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%	99.20%	99.00%	99.23%	97.59%	98.65%				98.90%	99.00%

RWT_EB4

The performance data for Diagnostic Tests was not submitted by RWT on the SQPR at Month 10, however, has been confirmed by the Trusts Board Reports as 98.67% and therefore breaches the 99% target (RED). Although performance represents an improvement from the December position (98.65%), performance remains below threshold for the third consecutive month. The Trust had previously confirmed that performance levels remained below target during December due to Magnetic Resonance Imaging (MRI) capacity issues and additional sessions were arranged during January to facilitate performance improvements. Following discussions with the Trust at the monthly CRM meeting, it has been confirmed that an additional issue has been identified with Radiography software incorrectly showing records as compliant and within target. This software issue affected approximately 50 patients and the system algorithm has been corrected by the system supplier to ensure data is correctly identified and reported. As part of the monthly NHS England Assurance Call, the Trust had confirmed that the February performance is predicted to see a decrease to 98.12% and therefore remains below the National target. Additional sessions have been scheduled and fully booked through to the end of March and the Trust are confident that performance will recover in April 2017. The National verified figures have confirmed that breaches occurred in January for both MRI (30 breaches out of 1,134 - 97.4%) and CT scans (38 breaches out of 538 - 92.9%) and these were the only two test areas which performed below 100% for January.

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%	92.33%	92.08%	91.47%	86.36%			89.98%	95.00%

The Month 10 performance has failed to achieve both the 95% National target (Type 1 and All Types) and STF trajectory (94%) and has seen a decline from previous months to 86.36%. The headline performance of 86.36% can be split into the following : Emergency Department New Cross - 77.44%, Walk In Centre - 100%, Cannock Minor Injury Unit (MIU) - 100% and Vocare - 97.24%. When compared to the previous years performance, there has been a decrease in compliance (Jan 15/16 = 89.31%, Jan 16/17 = 86.36%), however January 2017 saw an increase of 2084 attendances compared to January 2016 (a 12.5% increase in attendances). The Trust and CCG continue to hold Urgent Care teleconferences (3 per week) to discuss performance and actions. The joint triage process between RWT and Vocare has been in operation since September 2016 and will be reviewed before the end of March 2017, however the Trust have confirmed that improvements are being seen due to the triage process with Vocare especially at weekends. Patient Flow Rapid Improvement events have taken place at the Trust and facilitated by the Human Factors Project to look at new ways of working in Minor (injuries) and Major (injuries). Actions identified from the staff stakeholder events have been implemented including a trial of 4 hour shifts to address the Minor injuries peak (between 9am and 1pm) which following evaluation in February indicated a levelling of numbers within the department and the Trust have presented a business case to the A&E Delivery Board for further work within this area. Health Care Assistants (HCAs) and Support Assistants (for each shifts) have received training in plastering and from March 17, HCAs will also perform basic investigations (on request of the triage nurse) as part of the Minors triage process. Provisional Urgent and Emergency Care reported figures for January indicate that the decline in performance trend is consistent with other Acute Trusts within the region for the same time period (RWT - Dudley Group - 78.8% with 8,602 attendances, Walsall - 64.4% with 6,323 attendances, Sandwell - 78.5% with 13,931 attendances). Urgent Care performance (including ambulance conveyances) continues to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. The CRM meeting during February discussed the January performance and confirmed that the Trusts performance was in line with the current National trend and confirmed that the Trust performance is in the top 3 (in West Midlands) and top 40 (Nationally) against the 4hr hour wait target. The Trust confirmed provisional performance data for February as part of the NHS England Assurance Call and this indicates an increase to 89.7%, however remains below the STF and National target.

NHSE Update : The Royal Wolverhampton NHS Trust and Wolverhampton CCG have appealed the STF process for Q3 (as per the STF Financial Control Guidance demonstrating if there has been a material change eg due to changes in activity such as increases in GP referrals, attendances, other factors). NHSE have confirmed that the Trusts STF appeal has been supported and upheld for Quarter 3 and therefore the Q3 STF payment has been received by the Trust.

RWT_EB5

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%	96.98%	93.56%	98.40%	96.65%			95.97%	96.00%

The performance for January has seen a decline to 96.65% however remains above the 96% target. Due to previous below target performance the YTD performance remains below target (95.97%). Analysis of the Year on Year performance shows that the M10 performance is below that of 2015/16 for the same month (15/16 - 96.52%). The Trust have confirmed that issues with 31 day and 62 day cancer waits are linked to Urology and decreases in performance are due to on-going work to ensure long waiting patients are seen from the waiting lists.

RWT_EB8

An updated Remedial Action Plan (RAP) has been received from the Trust for 62 Day Cancer and this has been shared with the Cancer Network for review and requests for recommendations. 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 January confirm that the Trust achieved 97.49% (relating to 5 breaches out of 109 patients seen) and therefore GREEN. Early indications are that the February performance remains above threshold with a small decrease to 96.13%.

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%	91.67%	80.00%	72.97%	68.75%			84.37%	94.00%

The 31 Day Standard for subsequent treatment (Surgery) has seen a significant decrease in performance for Month 10 reporting 68.75% against the 94% target and is the lowest reported performance since 2013 (available comparable collated records from April 2013). This indicator is affected by small cohorts of patients with a total of 32 patients seen in January (22 of which breached target). The Trust have confirmed that issues with 31 day and 62 day cancer waits are linked to Urology and decreases in performance are due to on-going work to ensure long waiting patients are seen from the waiting lists. 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 January have now been confirmed as 71.43% (10 breaches out of 35) and therefore remains RED. Sanctions are based on Quarter end performance.

RWT_EB9

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%	70.00%	70.76%	80.41%	72.97%			76.29%	85.00%

The performance in Month 10 has seen a significant decrease to 72.97% and remains below both the STF trajectory and the 85% target in-month and YTD (76.26%).

The Trust have since confirmed via the Integrated Quality and Performance Report that there were 26 patient breaches in January (10 x tertiary referrals, 7 x capacity issues, 5 x patient initiated and 4 x complex pathways). Analysis by Cancer site confirms the breaches are relating to : Sarcoma (0.5 out of 0.5 - 0%), Urology (7 breaches out of 16 - 56.25%), Lung (3 breaches out of 7 - 57.14%), Colorectal (3 breaches out of 7 - 57.14%), Head & Neck (2 breaches out of 5.5 - 63.64%), Upper GI (1.5 breach out of 4.5 - 66.67%), Gynaecology (1.5 breaches out of 5.5 - 72.73%), Haematology (1 out of 8 - 87.50%), Skin (1 breaches out of 11.5 - 91.30%) and Breast (0.5 out of 11.5 - 95.65%). The Trust have confirmed that issues with 31 day and 62 day cancer waits are linked to Urology and decreases in performance are due to on-going work to ensure long waiting patients are seen from the waiting lists. The confirmed performance excluding tertiary referrals for Month 10 is 77.46% and therefore remains RED.

RWT_EB12

An updated Remedial Action Plan (RAP) has been received from the Trust and includes the following updated actions : A review of cancer services and appropriate mix of staffing levels and skills mix has been completed with management of change consultations concluding end of February. A 2nd Pelvic Oncologist post has been advertised and interviews have been set for beginning of April 2017 which will increase capacity to support Urology 31 day and 62 pathways, however the 2 middle grade vacancies have been unsuccessful in recruitment and interim arrangements for temporary cover have been made with a plan to re-advertise in March 2017. Urology clinics have been scheduled for Saturdays through to April 2017 to process the backlog of patients, however as all patients taken on from the backlog will have already breached, this will impact on the overall performance. Validated figures are received after the SQPR submission deadline as the final cancer figures are uploaded nationally 6 weeks after month end and January performance has been confirmed as 73.42% (21 patient breaching target out of 79) and therefore remains RED. The Month 10 performance was discussed at the February CQRM and CRM meetings with the Trust with an action carried forward to the March meeting to confirm the Harm Reviews Process for breaching patients.

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%	80.00%	95.65%	89.47%	85.71%			86.76%	90.00%

RWT_EB13

Performance in Month 10 has seen a decline from the previous month and has failed to achieve the 90% target both in-month (85.71%) and YTD 86.76%. The SQPR submission indicated that there was 1 breach (out of 7 patients) however the Trust have confirmed that the breach relates to 2 patients, both tertiary referrals so are counted as 0.5 of a breach each. Analysis of the Year on Year performance shows that the M10 performance is above that of 2015/16 for the same month (15/16 - 83.78%). The Trust have confirmed that this indicator is impacted by a small cohort of patients (predominately Urology patients) and is directly impacted by 62 Day urgent GP Referral to 1st definitive treatment performance issues. The Trust continue to schedule additional Saturday clinics for Urology. Following the previous Intensive Support Team (IST) visit and implementation of all their recommendations, the Trust have requested any further recommendations to aid improvement from NHSI (NHS Improvement) and the IST. The Trust have also confirmed that the January performance excluding tertiary referrals as 100% and therefore would be rated GREEN. 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 January confirm that the Trust achieved 88.89% (relating to 1 breach out of 9 patients seen) and therefore RED. The Month 10 performance was discussed at the February CQRM and CRM meetings with the Trust with an action carried forward to the March meeting to confirm the Harm Reviews Process for breaching patients.

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	49	23	23	25			388	0

RWT_EBS4

This indicator has breached the zero threshold for 52 week waiters as it continues to manage the outstanding long waiting Orthodontic patients following an in-depth review of waiting list practices. At the end of January, 25 patients were recorded as waiting over 52 weeks and the National Unify2 data has since confirmed that all the over 52 week waiters are Orthodontic patients. Following validation the January figure has since been confirmed as 19 patients waiting over 52 weeks. RTT performance (including 52 Week Waiters and Referral Diversions) continues to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. The Trust confirmed at the CRM meeting (February) that the number of Orthodontic patients waiting over 52 weeks was expected to rise in February due to the consultant for Orthodontics taking annual leave during the month. The Trust have planned for remaining patients waiting to be within the low teens and ahead of the local recovery trajectory for March 2017. As a commissioner, the CCG have 1 Trauma & Orthopaedics patient waiting over 52 weeks at the Royal Orthopaedic Hospital (Birmingham). The co-ordinating Commissioner (Birmingham Cross City) have been contacted for updates and it has been confirmed that the breach relates to a complex spinal deformity case. A Remedial Action Plan (RAP) is in place for all of the spinal deformity long waiters at the Trust however, due to the nature of the complex cases long waits are expected. As at the end of January, it has been confirmed that there are 5 additional Wolverhampton responsible patients waiting over 36 weeks at the Royal Orthopaedic for Spinal and Spinal Deformity treatment.

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%	90.00%	100.00%	90.00%	53.33%			84.70%	95.00%

BCPFT_LQGE05

Performance for this indicator saw a significant decrease in January and failed to achieve the 95% target both in month (53.33%) and Year to Date (84.70%). Performance is affected by small numbers and January breach refers to 7 clients (out of 15) failing to receive an initial assessment within 10 working days. The trust have confirmed the following :

2 x clients cancelled appointments (with both clients requesting a new date after the 7 days target)

4 x clients DNA'd (Did Not Attend) appointments within the 7 day target, with clients failing to attend multiple appointments.

1 x initial assessment offered 17 days after referral was received due to the Consultant being on annual leave The EIS service has reviewed the assessment process due to the increase in referrals and recommenced the assessment clinics as well as providing flexibility in offering appointments outside of the assessment clinics at venues more suitable and amenable to the individual client. The team continually review the service and reflect on incidents where the targets are not achieved and employ measures to address them. The Trust previously expected performance to meet target by January 2017, however due client DNA's and client choice superceded target dates this has now been updated to March 2017. The ability to meet this deadline is however dependant on the client choice.

Delayed transfers of care to be maintained at a minimum level

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD
9.67%	13.22%	13.62%	14.00%	18.45%	18.55%	18.87%	23.09%	26.73%	10.38%			16.66%

BCPFT_LQGE11

Delayed Transfers of Care (DTOCs) remain an on-going issue and this indicator has breached the 7.5% threshold since August 2015 with the current performance reporting at 10.38% (an improvement of over 16% on the December performance). The performance relates to the total number of delay days for the month (145) over the total number of occupied bed days excluding leave for the month (1397) and is based on the Provider total (all Commissioners) and currently cannot be split by individual commissioner. When compared to the previous years performance, there has been a positive decrease in compliance (Jan 15/16 = 14.17%, Jan 16/17 = 10.38%). Weekly bed management meetings continue with detailed discussions (with Local Authority, CCG and Trust representation) in order to agree how to move forward on each delayed patient. A detailed report showing the comparison between 15/16 and 16/17 YTD delayed discharge numbers continues to be shared with both the Sandwell and Wolverhampton A & E boards which is chaired by Trust Chief Execs. The A&E Delivery Boards have agreed to support the Trust in a focused piece of work to reduce delays which will ultimately have a positive impact across the Health economy.

The Head of Quality & Risk (WCCG) continues to press for a joint Local Authority/Trust and Commissioner meeting dedicated to the discussion of actions to address the DTOC issue. Difficulties have included the acknowledgment of differences between Social Care and Health DTOC definitions and processes. The issues with Delayed Transfers of Care remains an agenda item on the CCG's monthly performance call with NHSE and at the Trusts CQRM meetings. The Trust have confirmed that the number of delays (on the National reporting snapshot) has reduced with 2 patients (out of 50) classified as Delayed. With this reduction, the Trust expect to see the monthly occupied bed day figures reflect the same trend for the Month 11 report.

4. FORWARD LOOK – 2017/18 BUDGETS

4.1 Within the CCG's finance plan for 2017-19 there continues to be two areas of concern:

- The new IR (Specialised Services) rules as operated by NHSE and the impact on the CCG result in significant differences and the CCG is working closely with NHSE to resolve differences.
- The QIPP challenge in 2017-18

4 NHSE required the CCG to resubmit its 2017/18 plan on March 24th 2017 to reflect M11 and also the progress made in reducing levels of net risk and unallocated QIPP in line with NHSE guidance. Following an Executive review of the 17/18 budgets the net QIPP has reduced to £10.62m and schemes have been identified at a high level to cover the unallocated QIPP. In taking these actions the revised risk profile now presents a fully mitigated risk position. The Committee supported the revisions made to the plan to achieve this position.

5. Contract and Procurement Report

The Committee received the latest overview of contracts and procurement activities. There were no significant changes to the procurement plan to note.

6. Draft Finance and Performance Committee Annual Report

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

7. RISK and MITIGATION

Risks	Potential Risk Value Mth10	Full Risk Value £m	Probability of risk being realised %	Potential Risk Value £m	Proportion of Total %
CCGs					
Acute SLAs	0.41			0.00	0.00%
Community SLAs	0.00			0.00	0.00%
Mental Health SLAs	0.00			0.00	0.00%
Continuing Care SLAs	0.00			0.00	0.00%
QIPP Under-Delivery	0.00			0.00	0.00%
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	0.43	0.31	85.00%	0.26	100.00%
TOTAL RISKS	0.84	0.31		0.26	100.00%

- The table above details the current assessment of risk for the CCG; a gross risk of £0.31m but risk assessed to £0.26m. The reduction is risk level is associated with the agreed year end settlement with RWT which has now been factored into the reported financial position and reducing risk levels as the end of the financial year approaches.

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

Mitigations	Expected Mitigation Value Mth10	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	0.65	0.26	100.00%	0.26	100.00%
Delay/ Reduce Investment Plans	0.00			0.00	0.00%
Other Mitigations	0.00			0.00	0.00%
Mitigations relying on potential funding	0.19	0.00		0.00	0.00%
Actions to Implement Sub-Total	0.84	0.26		0.26	100.00%
TOTAL MITIGATION	0.84	0.26		0.26	100.00%

- Non Recurrent measures relate to the diversion of Drawdown funding to support the financial position and the use of SOFP flexibilities.
- The CCG has already committed its Contingency reserve of £1.78m therefore this cannot be considered as mitigation.

Other Risk

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

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

8. RECOMMENDATIONS

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

Name: **Lesley Sawrey**
Job Title: **Deputy Chief Finance Officer**
Date: **29th March 2017**

Performance Indicators 16/17

Current Month: Jan

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%	86.36%	R	89.98%	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%	95.18%	G	93.74%	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%	99.44%	G	95.89%	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%	96.65%	G	95.97%	R	↓	
RWT_EB9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery*	RWT	94%	68.75%	R	84.37%	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	99.69%	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%	98.33%	G	97.65%	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%	72.97%	R	76.29%	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%	85.71%	R	86.76%	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)	1.00	G	41.00	R	↑	
RWT_EBS4	Zero tolerance RTT waits over 52 weeks for incomplete pathways*	RWT	0	25.00	R	388.00	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	221.00	R	753.00	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	41.00	R	134.00	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%	96.69%	G	95.79%	G	↓	
RWTCB_S10B	Duty of candour	RWT	Yes	Yes	G	-	R	↓	
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%	92.85%	R	93.39%	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%	81.41%	R	82.88%	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%	1.80%	G	2.16%	G	↑	
RWT_LQR4	Serious incident (SI) reporting – SIs to be reported no later than 2 working days after the incident is identified.	RWT	0	2.00	R	8.00	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	7.00	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	11.00	R	↑	
RWT_LQR7	Number of cancelled operations - % of electives	RWT	0.80%	0.43%	G	0.44%	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_LQR13	Maternity - Antenatal - % of women booked by 12 weeks and 6 days	RWT	90.00%	91.02%	G	90.49%	G	↓	
RWT_LQR14	Stroke - Percentage of patients who spend at least 90% of their time on a stroke unit	RWT	80.00%	93.02%	G	89.73%	G	↑	
RWT_LQR15	Stroke - Percentage of higher risk TIA cases are assessed and treated within 24 hours	RWT	60.00%	63.79%	G	71.38%	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	7.00	G	63.00	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	57.00	G	383.00	G	↑	
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	17.00	G	66.00	R	↑	
RWT_LQR20	% Patients in receipt of TTOs within 4hours from the pharmacy receiving order	RWT	TBC	96.95%		96.92%	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%	74.02%	R	94.86%	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	→	

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
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%	96.91%	G	98.40%	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%	93.33%	R	96.68%	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%	100.00%	G	59.83%	G	→		
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%	94.30%	G	92.00%	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%	98.73%	G	99.52%	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%	100.00%	G	99.41%	R	→		
BCPFT_LQGE02	Percentage of EIS caseload have crisis / relapse prevention care plan	BCP	80.00%	91.30%	G	89.20%	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	38.00	G	38.00	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%	100.00%	G	59.83%	G	→		
BCPFT_LQGE05	Percentage of all routine EIS referrals, receive initial assessment within 10 working days	BCP	95.00%	53.33%	R	84.70%	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%	85.01%	G	91.02%	G	↑		
BCPFT_LQGE09	Evidence of using HONOS: Proportion of patients with a HONOS score	BCP	95.00%	96.09%	G	95.77%	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%	10.38%	R	16.66%	R	↑		
BCPFT_LQGE12	Emergency up to 4 hours. % of assessments relating to referral within period	BCP	85.00%	93.04%	G	89.98%	G	↓		
BCPFT_LQGE13	Urgent (up to 48 hours). % of assessments relating to referral within period	BCP	85.00%	94.12%	G	88.04%	G	↓		
BCPFT_LQGE14	Routine (up to 28 days). % of assessments relating to referral within period	BCP	85.00%	98.65%	G	98.56%	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	98.57%	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			

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
11 APRIL 2017

Agenda item 14

TITLE OF REPORT:	Summary – Remuneration Committee – 28 March 2017
AUTHOR(s) OF REPORT:	Jim Oatridge – Remuneration Committee Chairman
MANAGEMENT LEAD:	Claire Skidmore, Chief Finance and Operating Officer
PURPOSE OF REPORT:	To provide an update of key discussions and decisions made at the Remuneration Committee to the Governing Body.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• Policies on Annual Leave, Recruitment and Domestic Abuse were noted as having been ratified virtually. • The Committee noted that a 1% pay increase for staff on Agenda for Change had been announced. • The Committee noted that remuneration for interim chairing arrangements would need to be set.
RECOMMENDATION:	That the Governing Body receive and note the contents of this report.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
3. System effectiveness delivered within our financial envelope	<u>Continue to meet our Statutory Duties and responsibilities</u> The Remuneration Committee is responsible for ensuring that the CCG has appropriate Human Resources Policies and Procedures in place to deliver statutory responsibilities as an employer.

1. BACKGROUND AND CURRENT SITUATION

1.1 This report gives details of the issues discussed and decisions made at the meeting of the Remuneration Committee on 28 March 2017.

2. ITEMS CONSIDERED BY THE COMMITTEE

2.1. Policy Approval

The Committee noted that updated policies for Annual Leave and Recruitment had been ratified virtually by committee members. This had allowed the changes in the policy to be communicated to staff. A new Domestic Violence policy had also been approved.

2.2. Agenda for Change Pay Award

The committee noted that an announcement on the national pay award for staff on Agenda for Change pay and conditions had been made. Staff will receive a 1% consolidated uplift with effect from 1 April 2017. It was noted that the committee would need to meet to agree any uplift for staff and office holders on non-agenda for change contracts.

2.3. Interim Chairing Arrangements

The committee noted that any additional remuneration associated with the interim arrangements for Chairing the Governing Body would need to be agreed by the committee at a future meeting.

3. CLINICAL VIEW

3.1. There are clinical members who contribute fully to its deliberations.

4. PATIENT AND PUBLIC VIEW

4.1. Not applicable.

5. KEY RISKS AND MITIGATIONS

5.1. There are no specific risks associated with this report.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. There are no financial implications associated with this report.

Quality and Safety Implications

6.2. There are no quality and safety implications associated with this report.

Equality Implications

6.3. There are no equality implications associated with this report.

Legal and Policy Implications

6.4. CCG Policies for Annual Leave, Recruitment and Domestic Violence have been approved.

Other Implications

6.5. There are no specific Human Resources implications arising from this report. The Committee receives Human Resources advice when required.

Name	Jim Oatridge
Job Title	Remuneration Committee Chair
Date:	April 2017

ATTACHED:

(Attached items:)

RELEVANT BACKGROUND PAPERS
(Including national/CCG policies and frameworks)

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	Date
Clinical View	**N/a**	
Public/ Patient View	**N/a**	
Finance Implications discussed with Finance Team	**N/a**	
Quality Implications discussed with Quality and Risk 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**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/a**	
Any relevant data requirements discussed with CSU Business Intelligence	**N/a**	
Signed off by Report Owner (Must be completed)	**Jim Oatridge**	

NHS
Wolverhampton
Clinical Commissioning Group

BOARD ASSURANCE FRAMEWORK NOTES

(Please **DELETE** before submission)

Following a review of the BAF, it will now be based on the risks associated with the CCG achieving its strategic aims and objectives as follows:-

Strategic Aims	Strategic Objectives
1. Improving the quality and safety of the services we commission	a. Ensure on-going safety and performance in the system Continually check, monitor and encourage providers to improve the quality and safety of patient services ensuring that patients are always at the centre of all our commissioning decisions
2. Reducing health inequalities in Wolverhampton	a. Improve and develop primary care in Wolverhampton – Deliver our Primary Care Strategy to innovate, lead and transform the way local health care is delivered, supporting emerging clinical groupings and fostering strong local partnerships to achieve this b. Deliver new models of care that support care closer to home and improve management of Long Term Conditions Supporting the development of Multi-Speciality Community Provider and Primary and Acute Care Systems to deliver more integrated services in Primary Care and Community settings
3. System effectiveness delivered within our financial envelope	a. Proactively drive our contribution to the Black Country STP Play a leading role in the development and delivery of the Black Country STP to support material improvement in health and wellbeing for both Wolverhampton residents and the wider Black Country footprint. b. Greater integration of health and social care services across Wolverhampton Work with partners across the City to support the development and delivery of the emerging vision for transformation; including exploring the potential for an 'Accountable Care System.' c. Continue to meet our Statutory Duties and responsibilities Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework d. Deliver improvements in the infrastructure for health and care across Wolverhampton The CCG will work with our members and other key partners to encourage innovation in the use of technology, effective utilisation of the estate across the public sector and the development of a modern up skilled workforce across Wolverhampton.

This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
11 APRIL 2017

Agenda item 15

TITLE OF REPORT:	Summary – Primary Care Joint Commissioning Committee – 7 March 2017
AUTHOR(s) OF REPORT:	Pat Roberts, Primary Care Joint Commissioning Committee Chair
MANAGEMENT LEAD:	Mike Hastings, Associate Director of Operations
PURPOSE OF REPORT:	To provide the Governing Body with an update from the meeting of the Primary Care Joint Commissioning Committee on 7 March 2017.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	• Wifi is now available within all Wolverhampton GP Practices. • New models of care extended hours access scheme has been extended until the end of March 2017.
RECOMMENDATION:	The Governing Body is asked to note the progress made by the Primary Care Joint Commissioning Committee.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	The Primary Care Joint Commissioning Committee monitors the quality and safety of General Practice.
2. Reducing Health Inequalities in Wolverhampton	The Primary Care Joint Commissioning Committee works with clinical groups within Primary Care to transform delivery.
3. System effectiveness	Primary Care issues are managed to enable Primary Care Strategy delivery.

delivered within our financial envelope	

1. BACKGROUND AND CURRENT SITUATION

1.1. The Primary Care Joint Commissioning Committee met on 7 March 2017. This report provides a summary of the issues discussed and the decisions made at those meetings.

2. PRIMARY CARE UPDATES

Primary Care Joint Commissioning Committee - 7 March 2017

2.1 The Committee received the following update reports:-

- **NHS England**
  The Committee noted that NHS England have not received any updates from the regional or national team.

- **Wolverhampton CCG**
  The Committee were informed that wifi is now available within all GP practices and that Juliet Bower, Director of NHS Digital, will be visiting the CCG on 21 March 2017 as the CCG are the first CCG in the country to implement.

  New models of care extended hours access scheme has been extended until the end of March 2017 for practices within Primary Care Home 1 and 2.

  Primary Care Homes are putting together their next newsletters for patients to inform them of progress and remind them of the services available to them.

- **Primary Care Operational Management Group Meeting**
  The Committee noted that discussions have taken place around the monitoring of quality and assurance with regards to the Friends and Family Test and how to manage data submissions.

2.2 **Other Issues Considered**

The Committee met in private session to discuss a practice joining the vertical integration programme, a change in partnership at a Wolverhampton practice and the Primary Care Reserves Investment Plan.

3. CLINICAL VIEW

3.1. Not applicable.

4. PATIENT AND PUBLIC VIEW

4.1. Patient and public views are sought as required.

5. KEY RISKS AND MITIGATIONS

5.1. Project risks are reviewed by the Primary Care Operational Management Group.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. Any Financial implications have been considered and addressed at the appropriate forum.

Quality and Safety Implications

6.2. A quality representative is a member of the Committee.

Equality Implications

6.3. Equality and inclusion views are sought as required.

Legal and Policy Implications

6.4. Governance views are sought as required.

Other Implications

6.5. Medicines Management, Estates, HR and IM&T views are sought as required.

Name: Pat Roberts
Job Title: Lay Member for Public and Patient Involvement, Committee Chair
Date: 28 March 2017

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	Date
Clinical View	**N/A**	
Public/ Patient View	**N/A**	
Finance Implications discussed with Finance Team	**N/A**	
Quality Implications discussed with Quality and Risk Team	**N/A**	
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**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/A**	
Any relevant data requirements discussed with CSU Business Intelligence	**N/A**	
Signed off by Report Owner (Must be completed)	**Pat Roberts**	**28/03/17**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
Governing Body
11th April 2017

Agenda item 16

TITLE OF REPORT:	Report of the Primary Care Strategy Committee
AUTHOR(s) OF REPORT:	Sarah Southall
MANAGEMENT LEAD:	Sarah Southall
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 Implementation 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.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	• Four of the Task and Finish groups have reported slippage within their programmes of work. These have been accepted by the Committee and timescales amended. • There are no red risks associated within the delivery of work programme. • The Extended Opening Scheme for Saturday morning appointments has now been extended until the end of March 2017.
RECOMMENDATION:	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 by the committee
LINK TO BOARD ASSURANCE FRAMEWORK AIMS &	1 Improving the quality and safety of the services we commission : Ensure on-going safety and performance in the system 2 Reducing Health Inequalities in Wolverhampton : Improve

OBJECTIVES:	and develop primary care in Wolverhampton; Deliver new models of care that support care closer to home and improve management of Long Term Conditions. 3 System effectiveness delivered within our financial envelope : Deliver improvements in the infrastructure for health and care across Wolverhampton

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 programme of work was launched in the summer of 2016 and this report provides an overview of the progression taking place.

1.2. The CCGs vision is 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. This report provides an overview of progress reported in March 2017:-

- Program of Work Delivery & Governance Arrangements
- New Models of Care
- General Practice Five Year Forward View

2.2. The programme of work was largely performing in line with predicted timescales however, the Committee did receive four exception reports as follows: -

- **New Models of Care (Unity)**
  - The leadership roles and organisation structures were due to be completed at the end of February 2017. Although no formal roles have been identified, specific work streams are attracting engagement from a variety of members. The group feel they need to progress with identified priorities and establish roles as work streams evolve.
  - The evaluate data from participating Practices within the extended access scheme was due to be completed at the beginning of February 2017. As the scheme has been extended until the end of March the evaluation will therefore be completed once the additional clinics have finished.
  - The Group were to provide an audit of DNA rates by the end of March, the data continues to be collected along with other practice profile information and will be included for review in April.

- An update/presentation on Active Signposting / Staff training Pilot and the Case review of Paramedics supporting Primary Care discussions will be placed on the April meeting agenda.

- **Workforce and Development**
  - Work with Better Care Wolverhampton Programme to strengthen interfaces and develop a local workforce of multi-disciplinary practitioners was due to complete end February 2017, this has not completed due to a change of staff in the Better Care Team.
  - Develop a programme to train individuals from Wolverhampton as HCAs and practices nurses. This was due to complete in February 2017, however this is a longer term piece of work and the timescales will need adjusting to account for changes to pre-registration nurse training, higher apprenticeships and newer roles within primary care that need to be set up and then embedded into working practice.
  - Develop a programme to encourage and support those living in the area (with suitable qualification but not working or only working part time) to return to work/increase their working hours. This was due to complete February 2017, however a review of the completion date is needed as this has now been identified as a longer-term goal due to the proposed changes as stated above.
  - Ensure retention strategies are in place that supports innovative ways of retaining the workforce. This is underway as part of the wider strategy above around development and recruitment.
  - Work with neighbouring employers to standardise employment practice and opportunities. This will be in line with wider back office support functions being aligned with Primary Care Home and other models. This is an exception as the slip is due to this work not being able to begin until Primary Care Home models have settled in and newer ways of working are embedded into everyday practice.

- **Primary Care Contract Management**
  - Implementation of MCP/PACs emerging care model and contract framework, working in conjunction with NHS England. The delay is around preparing contracting plan for primary care in response to practice groupings. As well as ensuring the practice groups are sufficiently prepared to sub contract services where deemed necessary. This is partly due to the relatively recent release of MCP contracts and the associated guidance.
  - Review Memorandum of Understanding between NHS/CCG to understand the future relationship between the hub and CCG and to scope future resource requirements for Primary Care Contracting. This has been delayed as the updated Primary Care Hub Memorandum of Understanding has not been issued.

- **Estates Development**

- The three cohort 1 practices that were successful with ETTF bids should have had completed builds by 1 April 2017. Firstly due to the funding allocation taking longer than expected from NHS England and secondly lease agreements from NHS Property Services not being created, this has led to the programmes of work for each practice slipping beyond the original completion date.

Each report was considered and all exceptions were accepted by the Committee with the caveat that timescales for the New Models of Care (Medical Chambers) will be reviewed in May to ensure timely achievement.

2.3. The Program Management Office continues to support 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 March 2017 and the highlights are captured within the table below:-

Task & Finish Group	Highlights

Practices as Providers	• Discussions continue with regards to improved access to Primary Care. It has been identified that some areas of good practice which underpin the High Ten Impact Actions is already taking place. From this an overview plan has been developed to confirm how the 10 High Impact actions will be delivered and a Local Enhanced Service has also been prepared & shared with Group Leaders.
	• Work regarding non-clinical support functions continues with the Primary Care Home and Medical Chambers Groups to identify their preferred options for provision of each function. The functions include:
	  • Legal Services
	  • Human Resources
	  • Mandatory Training
	  • Payroll
	  • Standardised Policies and Procedures
	  • Business Intelligence and Data
	  • Medicine Optimisation and Prescribing Support
	  • Contract Management
	  • Procurement of Goods and Services
	
	• The Business Intelligence Team have presented data on GP referrals for the specialities with the greatest volume of activity and variance. This data will form the basis of Peer Review discussions in 2017/18 and a report has been provided to the Clinical Reference Group detailing the revied approach focussing on group level discussions.

	• A stakeholder meeting is due to be held to ensure community neighbourhood teams are aligned to groups of practices and a relaunch of Risk Stratification is agreed for 2017/18.
Localities as Commissioners	• A presentation was provided at Team W for GPs to hear about the ongoing work taking place in the city regarding 7 day services. • Work continues regarding the development of Practice Level Dashboards. A demonstration has been provided by Midlands and Lancashire CSU Business Intelligence Team on the practice level view of Aristotle. The report domains that can be generated at practice and group level on Aristotle include Contract Monitoring, Performance, High Intensity User Dashboard, Ambulatory Care Sensitive Conditions and Risk Stratification. The prescribing data is held by the Medicines Optimisation Team can also be included within the dashboards. • The Local QOF Steering Group have met and considered a Terms of Reference, meetings will be on a monthly basis. The Steering Group have reviewed other neighbouring CCGs approaches to implementing a local QOF and the intention is to develop a QOF+. Additional indicators are being identified and will be shortlisted in the coming months with a view to implementation during 2017/18.
Workforce Development	• Arrangements for the Workforce Fair continue, a has since been secured. • A further cohort for the Triumvirate Leaders Course (Health Education England) is due to commence in September 2017, recruitment is taking place over the coming months. • Work is due to commence with Wolverhampton University and Walsall around the provision of placement sites for Trainee Nursing Associates. • Root Cause Analysis training for all practice managers took on 10th March and a further session is planned for 6th April 2017. • The Committee queried the groups focus on GP training and the delay in the recruitment fair and it was agreed a more in depth report will be provided. • The risk log for the group was also discussed, new risks were identified. • The Head of Primary Care agreed to attend the next meeting to ensure other aspects of the programme of work were progressing accordingly, particularly in relation to general practice workforce.

Clinical Pharmacists in Primary Care	• Bids had been submitted for each model of care for funding for clinical pharmacists roles and the outcome had not yet been confirmed. • KPI data collection was being finalised & implementation to be agreed. • Gap Analysis work continues and a database is being kept up to date for practice coverage across the city.
General Practice Contract Management	• The Task and Finish Group met on the 1st March 2017. • The CCG issued an invitation for expressions of interest in relation to the Zero Tolerance Service, Primary Care Counselling and End of Life. • Medical Chambers Group were intending to hold an away day in April which will be hosted by Primary Care Commissioning to finalise priorities and direction of travel. • The final revised offer from NHS England primary Care (Contracting) Hub was awaited at the time of the meeting, this was received subsequently on 31 March 2017. • The role of a Primary Care Contracts Manager has been approved by the CCG. This role will lead on the responsibility associated with delegation of Primary Medical Services Contracts. • A meeting is being scheduled between the CCG and Wolverhampton City Council to explore joint procurement options.
Estates Development	• The Cohort 1 schemes have been delayed due to the delay in funding allocation from NHS England and lease agreements from NHS Property Services not being created. This has resulted in the programme of work for each practice slipping beyond the original completion date. Meetings are taking place with Practices so that lease agreements can be completed and CCG are providing support with this process.
IM&T	• EMIS Remote consultation projects have commenced within all the GP Groups in line with the GPFV Implementation Plan. • The Early Adopters WiFi Project has been completed and WiFi is now live. As the CCG were the first to go live NHS Digital will be visiting the CCG in May 2017. • ETTF Bid for 2017/18 has been submitted, which was in collaboration with Walsall CCG regarding expanding the existing Shared Care Record.

2.4 Each Task and Finish Group has a detailed programme of work that was also reviewed by the Committee in support of the performance detailed in the highlight and exception reports above.

2.5 Whilst there are risks attached to the delivery of this programme of work there are no red risks to report following discussions held at the March committee meeting.

3. NEW MODELS OF CARE

3.1 The CCG remain committed to supporting each model of care, Project Manager(s) were actively supporting both Primary Care Home(s) and the Medical Chambers groups of practices in their organisational preparedness for working at scale in response to the General Practice Forward View and Primary Care Strategy that feature within the CCGs Programme of Work for primary care development.

3.2 The extended opening scheme had been extended until the end of March 2017, funded locally by the CCG. This would enable practices to continue to provide additional appointments to their patients registered with Primary Care Home(s) 1 & 2. A hub model provided on Saturday mornings was demonstrating continued improvement in uptake. Other areas included in their update included:-

- Primary Care Home(s) 1 and 2 meetings have taken place within the month.
- A presentation was delivered by 'Sound Doctor' who provides a collection of information on patient advice, awareness and engagement.
- A number of service and pathway development meetings have taken place to agree requirements for Mental Health, Frailty and Clinical Pharmacists.
- Documentation that has been produced for validation by Primary Care Home(s) include Members agreement, Company accounts spreadsheets, invoicing template, expenses template, purchasing/revenue and costing and service evaluation.
- Primary Care Home(s) 1 and 2 are currently reviewing options for extended access as a collaborative approach across the City. This is with the view to developing an improved access plan to meet the latest NHS England Guidance and directives attached to the 10 high impact actions.

3.3 Medical Chambers are the largest group of practices working together focusing on managing demand, working at scale and identifying opportunities where they can work together to provide services. An update on the activities undertaken within the month is as follows:-

- The second Unity meeting took place on the 2nd March 2017. There was a presentation provided from NHS England on federated working and MCP contracts and a further presentation on Social Prescribing.
- The outcome of the clinical pharmacist bid to NHS England is still awaited.

- An optimisation event with EMIS regarding remote consultations has been arranged for the 5th April 2017.
- The winter pressures increased access has been extended until the end of March 2017. All the Practices have agreed to continue until the end of March and provide data and an evaluation report upon completion.
- A review paper on the proposed changes to the peer review process has been submitted to the Clinical Reference Group. This proposal seeks to agree a number of specialities for review during 2017/18 based on group level reviews. This approach has been agreed in principle.

3.4 A smaller cohort of Practices have sub-contracted their general medical services contracts to the Royal Wolverhampton Trust, there are currently 5 practices covering a population of approximately 30,000 patients. Identification of high risk patients and supporting those with long term conditions are current priorities that is resulting in closer working between primary and secondary care.

An induction meeting had taken place with the Trust's Primary Care Directorate Manager who has been invited to attend future Primary Care Strategy Committee Meetings. The trust have been requested to provide a highlight report for the Primary & Acute Care Model to confirm the work they are undertaking and alignment with the citywide CCG Primary Care Strategy.

3.5 The committee were also appraised of the new arrangements for Zero Tolerance. A newly procured service was due to commence in the city in April, in accordance with the CCG's fully delegated status. The new provider was due to be announced early in April.

3.6 The committee also considered a locally developed implementation plan in response to the General Practice Forward View. The plan had been submitted to NHS England for final approval however, the committee noted the content and programme of work & associated funded attached to successful implementation of the forward view.

4. CLINICAL VIEW

4.1. There are a range of clinical and non-clinical professionals leading this process in order to ensure that the leadership decisions are clinically driven. Clinical representation at many Task and Finish Groups takes place on a regular basis.

5. PATIENT AND PUBLIC VIEW

5.1. Whilst patients and the public were engaged in the development of the strategy and a commissioning intentions event held in the summer specific to primary care the Governing Body should note that Practice based Patient Participation Groups are being encouraged to ensure their work with the practice(s) encompasses new

models of care and the importance of patient and public engagement moving forward.

5.2. An update on Primary Care was provided to the Patient Participation Group Chairs in March, whilst this was welcomed they have requested further clarity regarding their involvement in the future in discussions with their respective models of care/practice groupings. Therefore, arrangements are being made for each group of PPG Chairs to meet with the CCG and the Group Lead(s) to discuss how this will be achieved and to ensure patients and the public are invited to share their suggestions on areas for improvement and take part in discussions about changes affecting patients.

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.

NHS
Wolverhampton
Clinical Commissioning Group

Name **Sarah Southall**
Job Title **Head of Primary Care**
Date **3 April 2017**

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	Date
Clinical View		
Public/ Patient View	**Pat Roberts**	**3.4.17**
Finance Implications discussed with Finance Team	**NA**	
Quality Implications discussed with Quality and Risk Team	**Manjeet Garcha**	**3.4.17**
Equality Implications discussed with CSU Equality and Inclusion Service	**NA**	
Information Governance implications discussed with IG Support Officer	**NA**	
Legal/ Policy implications discussed with Corporate Operations Manager	**NA**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**NA**	
Any relevant data requirements discussed with CSU Business Intelligence	**NA**	
Signed off by Report Owner (Must be completed)	**Steven Marshall**	**3.4.17**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
11 April 2017

Agenda item 17

TITLE OF REPORT:	**Communication and Participation update**
AUTHOR(s) OF REPORT:	Pat Roberts, Lay member for PPI Helen Cook, Communications, Marketing & Engagement Manager
MANAGEMENT LEAD:	Pat Roberts – Lay member for PPI
PURPOSE OF REPORT:	This report updates the Governing Body on the key communications and participation activities in March 2017.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This report is intended for the **public** domain
KEY POINTS:	The key points to note from the report are: • **2.1.1 Stay Well this Winter– Stay Well campaign advan and outreach** • **2.1.4 Demand Management – Play Your Care Right** • **4.1.1 You said – we did**
RECOMMENDATION:	• **Receive** and **discuss** this report. • **Note** the action being taken.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	• Involves and actively engages patients and the public. Uses the Engagement Cycle. – Commissioning Intentions. • Works in partnership with others.
2. Reducing Health Inequalities in Wolverhampton	• Involves and actively engages patients and the public. Uses the Engagement Cycle. – Commissioning Intentions. • Works in partnership with others. • Delivering key mandate requirements and NHS Constitution standards.
3. System effectiveness delivered within our financial envelope	• Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework.

1. BACKGROUND AND CURRENT SITUATION

1.1. To update the Governing Body on the key activities which have taken place in March 2017, to provide assurance that the Communication and Participation Strategy of the CCG is being delivered effectively.

2. KEY UPDATES

2.1. Communication

2.1.1 **Stay Well this Winter– official campaign**

The 2016/17 Stay Well This Winter campaign, jointly led by NHS England and PHE, is running 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.

Locally, our joint winter campaign will mirror the national stay well campaign until end of March 2017, particularly targeted to pregnant women, children under 5 and those with long term conditions.

On 24 and 27 March an Advan travelled around the city advertising the Stay Well in Wolverhampton message.

We have also done some more targeting outreach events during March, particularly with community groups such as, Refugee and Migrant Centre, Patient and Participation Groups along with others.

https://wolverhamptonccg.nhs.uk/your-health-services/stay-well-this-winter - the CCG Stay Well webpages which will be updated with new information.

2.1.2 **Patient online**

During March we assisted 25 GP practices across the city to encourage sign up to the practice patient online services.

Staff worked with GP staff to highlight the benefits to signing up to patient online to patients attending their surgery, and facilitated completion of the paperwork with patients to start the process to use individual surgery online services.

2.1.3 **Proactive press releases**

During Feb and March (to date) we issued eight proactive press releases. These can be found at the following page on our website. https://wolverhamptonccg.nhs.uk/news

2.1.4 **Demand Management – Play Your Care Right**

Following on from the Demand Management Game Show animation being shown at the March Governing Body meeting, we have started to disseminate the animation publically with a press release and a schedule of tweets to start it going on social media.

The animation has been designed as we acknowledge that navigating the health system can often be confusing, and to help address this, a fun new game show animation has been created to let everyone know how to 'Play Their Care Right'.

The animation can be found here https://wolverhamptonccg.nhs.uk/your-health-services/advice-on-health-care, giving just a few examples of where to go for a number of different conditions, ranging from a sprained ankle and cough, to severe chest pain and even head lice.

Options include pharmacy, self-care (looking after yourself), GP, walk in centre and A&E, plus a lifeline 111 button.

2.1.5 **Musculoskeletal (MSK) services**

Communications have gone out on the CCG website, a press release and via current internal communications channels to stakeholders to inform them of the new provider of the MSK service from April 2017. WCCG has recently awarded a five year contract to Connect Physical Health Centres Ltd. The new service, will provide assessment and treatment for adults over the age of 18 who are registered with a GP in Wolverhampton. The service will provide assessment and treatment in the community for orthopaedic and rheumatological conditions and will include pain management, physiotherapy and orthotics (ready-made).

2.2. Communication & Engagement with members and stakeholders

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 2017 Practice Nurse Bulletin went out in mid March. Topics included: MSK Update, Workforce update, CHC Assessments, Beat the Street campaign, learning from reviewing care and leaflets for vulnerable groups.

2.2.3 **Practice Managers Forum**

The March PM Forum covered the following topics:

- Bowel screening service presentation
- Social prescribing team introductions
- Violent patient scheme
- Specsavers presenting around the MECS service
- Carers support presentation
- Patient partner reminder and leaflets distribution
- Nuffield health introduction
- Care Navigating

2.2.4 **Annual Report**

Work has begun with Finance Dept., CCG staff and partners to collate WCCG Annual Report, ready for its first submission to NHSE in mid April.

3. CLINICAL VIEW

GP members are key to the success of the CCG and their involvement in the decision-making process, engagement framework and the commissioning cycle is paramount to clinically-led commissioning.

4. PATIENT AND PUBLIC VIEWS

Patient, carers, committee members and stakeholders are all involved in the engagement framework, the commissioning cycle, committees and consultation work of the CCG.

Reports following consultations and public engagement are made available online on the CCG website. 'You said – we did' information is also available online following the outcome of the annual Commissioning Intentions events and decision by the Governing Body.

4.1 Commissioning Intentions

4.1.1 **'You said – we did'**
Following on from the public engagement for Commissioning Intentions in 2016, we have now published the 'You said – we did' which outlines how what you've told us has influenced our commissioning for 17/18. The report can be found here https://wolverhamptonccg.nhs.uk/images/You_said_we_did_17-18.pdf

4.1.2 **Planning for 17/18**
Planning for next 2017 Engagement Commissioning Cycle continues with the public event is now fixed as May 17 – 19 inclusive and the event bus will be sited in many local areas throughout this period.

4.2 PPG and Citizens Forum

The PPG/CF meeting was held on 21 March and included an update on Primary Care and New Models of Care, the STP and request for patient stories. It was also agreed to hold individual models of care meetings between the PPG chairs and representatives of the models facilitated by the Primary care and engagement teams.

5. KEY RISKS AND MITIGATIONS

N/A

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. None known

Quality and Safety Implications

6.2. Any patient stories (soft intelligence) received are passed onto Quality & Safety team for use in improvements to quality of services.

Equality Implications

6.3. Any engagement or consultations undertaken have all equality and inclusion issues considered fully.

Legal and Policy Implications

6.4. N/A

Other Implications

6.5. N/A

Name: Pat Roberts
Job Title: Lay member for PPI
Date: 27 March 2017

ATTACHED:

none

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)
NHS The General Practice Forward View (GP Forward View), April 2016

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	**Date**
Clinical View	**n/a**	
Public/ Patient View	**PPG / CF meeting You said-we did**	**21/03/17 2016/17**
Finance Implications discussed with Finance Team	**n/a**	
Quality Implications discussed with Quality and Risk 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**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**n/a**	
Any relevant data requirements discussed with CSU Business Intelligence	**n/a**	
Signed off by Report Owner (Must be completed)	**Pat Roberts**	**27 March 2017**

NHS
Wolverhampton
Clinical Commissioning Group

MINUTES OF THE QUALITY & SAFETY COMMITTEE HELD ON 14th FEBRUARY 2017, COMMENCING AT 10.30AM, IN THE MAIN CCG MEETING ROOM, WOLVERHAMPTON SCIENCE PARK.

PRESENT:	Dr R Rajcholan	-	WCCG Board Member (Chair)
	Manjeet Garcha	-	Executive Director of Nursing & Quality
	Pat Roberts	-	Lay Member Patient & Public Involvement
	Sukhdip Parvez	-	Quality & Patient Safety Manager
	Kerry Walters	-	Governance Lead Nurse, Public Health
	Jim Oatridge	-	Lay Member, WCCG
	Steven Forsyth	-	Head of Quality & Risk
	Annette Lawrence	-	Designated Adult Safeguarding Lead
	Peter McKenzie	-	Corporate Operations Manager
	David Birch	-	Head of Medicines Optimisation
	Fiona Brennan	-	Designated Nurse for Looked after Children
	Molly H-Dillon	-	Quality Nurse Team Leader
	Juliet Herbert	-	Equality & Inclusion Business Partner
	Dawn Bowden	-	Quality Assurance Co-ordinator
	Matthew Boyce	-	Quality Assurance Co-ordinator
	Philip Strickland	-	Administrative Officer
APOLOGIES:	Marlene Lambeth	-	Patient Representative

1. APOLOGIES & INTRODUCTIONS

Introductions were made and the above apologies were noted by members.

2. MINUTES & ACTIONS OF THE LAST MEETING

2.1 Minutes of the 10th January 2017

The minutes of the meeting held on the 10th January 2017 were approved as an accurate record with the exception of the following amendments:

On page 4 paragraph 2 should read that ‘a Pharmacy had been prescribing a higher cost drug than was necessary.’ The comment ‘purely for profit’ was redacted from the previous minutes.

On page 5 paragraph 5 SF wished to clarify that although numbers attending the Urgent Care Centre had increased, the levels of activity were still way under the levels that were initially anticipated.

2.2 Action Log from meeting held on the 10th January 2017

The Action Log from the Quality & Safety Committee (QSC) held on the 10th January 2017 was discussed, agreed and an updated version would be distributed with the minutes of this meeting.

Patient Stories

MG reported that she had discussed sourcing Patient Stories from Black Country Partnership Foundation Trust (BCPFT) and The Royal Wolverhampton Trust (RWT) with their respective Directors of Nursing highlighting that providing the stories to other organisations required a further consent process beyond the patient's initial consent. BCPFT had been willing to consider adding further consent to their consent form for use of their patient story with Wolverhampton CCG. MG stated that at this stage RWT had not been willing to consider this approach. MG stated that the Director of Nursing of RWT Cheryl Etches would be visiting the CCG in the coming weeks to shadow the Quality Team in the work that they do. MG believed this would be an ideal opportunity to raise the issue of patient stories with the Director of Nursing. PR wished to state that it would be important to emphasise that it is the CCG's responsibility to put the patient at the heart of the work that is undertaken by the CCG. MG stated she would propose the alignment of the consent forms with RWT and BCPFT.

ACTION: ***MG to propose alignment of Patient Story consent forms with RWT and BCPFT***

Quality Assurance in CHC

It was confirmed that the financial underspend in 2015/16 as reported at the December meeting had been the result of several high cost cases that were found no longer eligible on their CHC review and a couple of very high cost cases that had sadly passed away. This action was therefore closed.

Draft Governing Body Minutes

It was agreed that the Draft Governing Body minutes would continue to be seen at the QSC as all amendments are reflected in subsequent minutes. This action was therefore now closed.

Triumvirate Leadership Programme

MG stated that it had been reported to her that Penn Manor had been selected as the practice to be involved with the Triumvirate Leadership Programme. MG was waiting for

further confirmation from Helen Ryan. It was also noted that a second cohort of practices were expected to be involved from April 2017.

3. DECLARATIONS OF INTEREST

No declarations of interest were raised.

4. MATTERS ARISING

4.1 Vacancy Breakdown – Black Country Partnership Foundation Trust (BCPFT)

SP confirmed that an enhanced breakdown of vacancies had been provided by BCPFT. The breakdown highlighted to the committee that there had been a vacancy rate of 13.37% of Nurses and 24.7% of medical staff. Band 5 nurse vacancy rates were noted at 16.7% and the Band 6 vacancies had been at 12.8%. SP highlighted that the most alarming statistic related to the vacancy rate of Junior Doctors at 49.31% which added pressure to the middle grade doctors which had a vacancy rate of 25.6%. SF wished to highlight that BCPFT would cease the use of all agency staff from April 2017. SF stated it would be important to see how this overall BCP Trust wide vacancy breakdown impacted on Wolverhampton. JO stated that the overall numbers were concerning.

4.2 QNA – Step Down

MD was in attendance to provide a current update on the Step Down of patients. Following an increase in numbers and rising costs relating to Step Down, MD confirmed that a Band 6 Step Down Advisor had been appointed from June 2016. The advisor had been based at the CCG working between care homes and the Acute Trust to monitor the Step Down list and the patients within Probert Court, to ensure that patients are not spending any longer in the Trust than was deemed necessary and to ensure they are referred to the correct provision. MD confirmed that there had been a marked improvement in Step Down at the moment. MD stated that for 2015/16 there had been 299 patients that had been through Step Down (excluding Probert Court) this equated to 10,400 bed days at a cost of £1.1million. MD added that at month 9 for 2016/17 there had been 179 Step Down patients equating to 4870 bed days at a cost of £400k. This was noted as a marked improvement by the Committee.

MD stated that there are still some areas of concern relating to the acute trust around poor communication, and paperwork not being completed correctly or sent out in a timely manner to the appropriate care provision. MD stated that these concerns are raised through quality matters and to the Integrated Care Team at the acute Trust.

MD wished to highlight a distinct pressure around Therapy services due to a lack of Therapists. Indeed it was noted that if the Trusts Therapy Services had been under pressure, Therapists would be pulled from the Step Down service in the first instance. It was confirmed that a business case would be pulled together to recruit Therapists to ensure there would be adequate provision.

PR highlighted a local patient account in which a patient had been stepped down to Bentley Court. PR highlighted that there had been no attempt made by Bentley Court to rehabilitate the patient appropriately. MD stated that ideally in this instance the patient

would have benefitted from a package of care from their own home as opposed to being Stepped Down to Bentley Court.

It was noted by the committee that 50% of patients in Step Down had been awaiting Therapy provision. MG highlighted that added a cost pressure to the CCG.

MD wished to highlight to the committee that Probert Court had been used as the first choice for Step Down patients as ensure that the quality of the care can be closely monitored. MD added that Probert Court had an appropriate set up for Step Down patients however if Probert Court had not been available a Care Home from the CCG Care Home Framework would be encouraged to be used. MD added that any concerns with the homes are raised through Quality Matters.

5. FEEDBACK FROM ASSOCIATED FORUMS

5.1 Draft CCG Governing Body Minutes

The minutes were noted by the committee.

5.2 Health & Wellbeing Board Minutes

No minutes were available for the current month.

5.3 Quality Surveillance Group

No minutes were available for the current month.

5.4 Primary Care Operational Management Group

The minutes were noted by the committee.

5.5 Draft Commissioning Committee Minutes

The minutes were noted by the committee.

5.6 Pressure Injury Steering Group

No minutes were available for the current month.

6.1 Monthly Quality Report

SF confirmed a concern had been raised with regard to Mortality, indeed NHSE and NHSI had published their escalated SHMI. SF confirmed that RWT is now the 3rd highest HSMR in the country. SF confirmed that an email had been received from the Medical Director stating that it was not believed that RWT do not have significant excessive preventable deaths. NHSI have raised a list of actions that they wish RWT to undertake including a peer review.

SF also wished to highlight a fall that had occurred on Ward C19 in mid-January which has now been pursued through a police investigation and subsequent media attention may be drawn upon this as a result.

SF confirmed that a Remedial Action Plan (RAP) meeting had been arranged with Vocare following the QSC to address element of safety of the Urgent Care service which have been raised in the past few weeks.

SF raised the committee's attention to 2 self-harm incidents that had occurred at BCPFT as detailed in the submitted report.

******In the essence of time management at the meeting the chair requested that all comments for this item be circulated via Philip.strickland@nhs.net by Close of Business on Friday the 17th February 2017 for review at the next meeting******

6.2 Safeguarding Children & Looked After Children Quarterly Report

LM reported that The WCCG self-assessment contains 13 standards relating directly to Safeguarding Children. This continues to be updated quarterly with 2 standards continuing to be rated as amber. These included awaiting the final ratification of DV Policy for WCCG Employees and Managers and completion of a TNA and implementation of a safeguarding training programme for all WCCG staff.

LM highlighted that a template had been developed by the WCCG Safeguarding Team which reflected the Safeguarding Assurance Framework for Services Commissioned by WCCG. This has been agreed to be used by the Heads of Safeguarding for RWT and BCPFT prior to its inclusion in contracts 2017/18. This template enabled thoroughness of reporting through the relevant Safeguarding Dashboard.

It was confirmed that the OFSTED inspection had now taken place from the 16/01/17 for 4 weeks as detailed in the report and the final judgement would be published on the 31st March 2017.

LM stated that following the CQC review in July 2016 the draft reported was released for comment and all comments have now been returned in anticipation of the final report. It was also noted that on the 5th December 2016 the CCG led Strategic Group had met to review the Joint Action Plan that was developed by WCCG in response to the issues identified immediately following the review. The first update to Wolverhampton Safeguarding Children Board (WSCB) was presented on 6th December 2016. Further updates are planned.

In terms of Serious Case Review (SCR) LM reported that on 21st November 2016 a baby died as a result of non-accidental injuries in Wolverhampton. Mother and her partner have been charged with murder. On 6th December 2016 the WSCB SCR committee met and a unanimous decision was reached to recommend to the independent chair of WSCB that the case should progress to a SCR. Once agreement has been obtained the SCR process will be implemented.

It was also noted that Walsall Serious Case Board (SCB) is conducting a SCR for a child who died on 12th June 2016. WCCG is involved in the SCR as the child is registered with a Wolverhampton GP. LM stated that in order to ensue collaborative working a member of WCCG attended the Practitioner Learning and Reflection Day as requested.

LM highlighted that concerns had been raised regarding the capacity and resilience of the safeguarding health presence in the MASH. LM added that as a result of the concerns being raised the WCCG Designated Nurse Safeguarding Children met with the Head of

Safeguarding from The RWT and the Associate Director for Safeguarding Adults and Children BCPFT on 22nd November 2016. LM continued that following the meeting an initial action plan was formulated and fully implemented. A meeting has been arranged with the health team and their line managers for early January 2017 to provide on-going support. The issues detailed were raised at the Wolverhampton Safeguarding Children's Board (WSCB) in December 2016.

With regard to Looked After Children (LAC) FB reported that a breakdown had been provided of Looked After Children (Table 1 of the report) as the number progress throughout the financial year. FB stated that whilst it was evident that the numbers continued to slowly decrease, it remained slow, with a total of 45 less children in care over the year. FB added that the percentage of those placed out of Wolverhampton remained around the 60% mark and did not appear to improving over the reporting year.

FB informed the committee that a business case submitted by Designated LAC Professionals, recommending changes in the way we commission LAC services in the future was approved by the CCG in Nov 2016 and discussions are currently underway with Provider services around its implementation. FB added that the focus of the proposal was to improve health provision and oversight of children placed outside of Wolverhampton and provision of dedicated health support for our Care Leavers.

It was confirmed that the Designated Doctor for LAC had left the CCG in December 2016 to take a year out. Her role within the WCCG was to be be replaced by the current Named Doctor for LAC employed by the RWT. JO stated he had picked up from the Monthly Quality Report that there perhaps would be a conflict of interest as a result of the changes. MG highlighted that the Designated Doctor for Looked after Children (LAC) was now Dr Stephanie Simons who was also covering the Named Doctor role for the provider. MG stated that this conflict of interest had been raised with the Medical Director for address. It was confirmed that Dr Claire Thomas had submitted notice in her role as Designated Doctor for Safeguarding Children.

FB stated that she had been had been asked by NHS England to produce a list of Key Performance Indicators (KPI's) that can be shared with the National LAC Group, with a view to uploading to a NHSE repository. This would provide an exemplar of best practice and positively impact on WCCG assurances from Provider services, improving outcomes for our children in care.

FB confirmed that since June 2015, Kent had seen an unprecedented rise in the number of young people arriving through the Port of Dover and The Channel Tunnel. From the 1st July 2016 Unaccompanied Asylum Seeking Children and Young People (UASCs) arriving in Kent would be dispersed to the on-going care of other Local Authorities, as advised by the UK Government so that no individual local authority bears a disproportionate share of the burden. Indeed FB added that to mitigate against health and safeguarding risks prior and during the transfer process, UASCs will be registered with a Kent GP and have an NHS number allocated. They would then be required to re-register with a GP in their new area on arrival and the new GP would then request the existing GP record. FB confirmed that a local process and flowchart would be developed.

SF questioned if any risk was posed to the organisation in terms of the CCG not having a ratified Domestic Violence policy in place? LM confirmed that there is an overarching regional policy in place and therefore there was no immediate risk highlighted.

6.3 Medicines Optimisation Quarterly Report

David Birch was in attendance to present the Medicines Optimisation Quarterly Report. From the report DB highlighted the safety alerts that had been received through September, October and November 2016. DB wished to highlight that retigabine 9treatment for epilepsy) was to be discontinued from June 2017 as there are various other available treatments. It was noted that there had been adverse drug reactions to the treatment. DB reported the discontinuation from December 2016 of Asasantin as other generic drugs are available.

It was reported that the Keppra® Oral Solution had several measures put in place to ensure that the correct dosing syringe is used to measure Keppra oral solution, and thus avoid medication errors. It was noted that Keppra (levetiracetam) is a medicine used to treat epilepsy in adults and children.

DB stated that it had been highlighted through the safety alerts that some patients may have exacerbation or rebound symptoms of rosacea. It is important to initiate treatment with a small amount of gel and increase the dose gradually, based on tolerability and treatment response.

DB stated that the alerts detailed in the report are then worked through by the Primary Care Medicines Team (PCMT) with a focus upon savings and medication safety. It was indeed highlighted from the report that the team had 160 patients prescribed etoricoxib, rheumatoid arthritis or ankylosing spondylitis, at a dose greater than 60mg/day to GPs for review.

DB reported that the 'Eclipse Live' alerts system had highlighted 52 possible safety alerts. The PCMT had continued to focus renal alerts including low potassium and prescribed diuretic, low sodium and prescribed bendroflumethiazide and risedronate and stage 4 renal failures.

The committee were highlighted to PCMT Patient contacts between October and December 2016. From the reported chart on page 84 of the meeting pack SF questioned what contacts were categorised as 'other'? DB stated that this would vary widely. SF asked if it would be possible to theme the 'other' category in a future report.

ACTION: ***DB to provide themes for the 'other' category for PCMT Patient Contacts in the next Quarterly Report.***

The committee discussed the best pathway for patients addicted to prescription drugs whether through addiction services or a referral to a Psychiatrist. It was noted that Public Health had oversight of the appropriate pathways.

DB confirmed that good progress had been made on the use Hypnotics and Anti-Biotics and highlighted the tables of usage by GP practice through Page 87 to 89 of the meeting pack. DB highlighted that the Showell Park Health & Walk in Centre still featured prominently in Anti-biotic prescribing. DB stated that Showell Park was still providing out of hours cover for GP practices and this would continue to distort the figures of Anti-Biotic prescriptions. The figures from Showell Park are still incorporating figures from when it had been operating as an 'Urgent Care Centre'.

PR requested if it would be possible to see the Volume of out of hours prescribing in a future report. DB stated that this would be reported as a flat figure as there would be nothing to benchmark against.

DB highlighted to the committee the submitted Hospital Electronic Discharge Summaries Audit undertaken in July 2016. The Primary Care Medicines Team was required to undertake an annual audit of the quality of Royal Wolverhampton NHS Trust hospital discharge summaries. This year's audit had focussed on the effectiveness of the e-discharge process. DB stated that there had been a number of issues raised by GP relating to the numbers of duplicate copies of the discharge summaries which had been causing confusion. DB reported that incorrect discharge summaries had the potential to cause medication incidents. DB highlighted that this was the 1st time that this kind of Audit had been undertaken. DB stated that findings had been shared with the Pharmacy Team at New Cross. MG confirmed that examples of draft and final discharge letters had been discussed at the RWT Clinical Quality Review Meeting (CQRM) to highlight some of the significant differences on specific examples.

6.4 Quality Assurance in Care Homes Quarterly Report

MHD introduced her Quarterly update by confirming that the Promoting Safer Provision and Care for Elderly Residents (PROSPER) had been rebranded to reflect the local landscape of Wolverhampton and Walsall. The programme was confirmed as being branded as the Safer Provision and Care Excellence (SPACE).

MHD reported that the CCG was now in Year 3 of the Care Home Improvement Plan 2014/17 (Appendix 1 of the submitted report) which continued to build on the successes delivered by the Quality Nurse Advisor (QNA) team during the first two years, utilising quality frameworks, tools and the development of care home managers. MHD stated that the QNA team also continued to support the safeguarding agenda by working collaboratively with the Local Authority, the Multi Agency Safeguarding Hub (MASH), CQC and the care home sector providing oversight and support with Root Cause Analysis (RCA), SI (serious incident) and Section 42 investigations. It was confirmed that sharing lessons learnt continued to form the fundamental element for driving up quality and reducing harms during the quarter.

MHD highlighted that Lessons learnt from the avoidable Pressure Injuries (PIs) highlighted that care home staff need to make improvements in record keeping, implementation of care planned and timely escalation. The QNA team will continue to facilitate targeted areas of training in the sector for the homes concerned.

MHD stated that there had been an increase for this quarter of 31 safeguarding and Quality concerns. It was added that 12 referrals had been reported for the previous quarter. MHD stated that the team would continue to monitor this closely with the Local Authority.

MHD reported that the Ruksar nursing home had now closed and all residents had moved out on the 23rd January 2017 following suspension in August 2016. PR enquired how many residents had been moved? MHD confirmed that there had been 21 residents moved from the home.

It was noted that overall number of attendances at A&E/AMU during Quarter 3 was 108 up on Quarter 2 when 85 attendances were reported. It was added that during the quarter October reported the highest number of attendances at 48 whilst November reported 33

and December reported 29 attendances. MG stated that perhaps it would be useful to capture information of those patients that had attended A&E and then had been discharged within 24 hours to highlight if all those referrals had been wholly necessary.

MHD confirmed that participation in the NHS Safety Thermometer for Quarter 3 had remained relatively low with 8 – 10 care homes participating. However of those homes submitting data monthly, harm free care percentage is averaging at 96-98% over the target of 95%. MHD added that three care homes had consistently achieved 100% harm free care during the quarter with 6 homes achieving 100% harm free care during November.

MHD confirmed that the SPACE (Safer Provision and Care Excellence) programme hosted its first care homes conference in November. Recruitment to the 2nd QNA post had been successful with start dates confirmed. MHD stated that Care home managers' and champions meetings/workshops continue and further quality improvement training is planned for March. It was noted that early evaluation by Birmingham University had been extremely positive, in that Wolverhampton care homes returned 46.5% questionnaires compared to Walsall care homes response rate of 26.2%; making a combined rate of 38.7%. MHD stated that Wolverhampton's baseline meant that the safety climate score had been recorded at 84.2 for safety climate compared to the national mean average and benchmarking data of around 70%. This concluded that the safety climate across the 2 boroughs had been higher than first anticipated.

6.5 Quality & Risk Action Plan

This item had been deferred until the March 2017 QSC.

6.6 Board Assurance Framework (BAF) and Risk Register

MG introduced Matt Boyce and Dawn Bowden due to their involvement with the on-going Board Assurance Framework and Risk Register. MG stated that the submitted report gave an overview of the PwC internal audit of the CCGs Risk Management Report which had rated the CCG as 'High'. MG added that of the 7 areas examined 3 areas are rated as High and 4 are rated as Low. The 3 areas MG wished to highlight to the committee were the 3 high risk areas which included:

1. Structure of the BAF and identification of strategic risks
2. Lack of risk ownership
3. Evidence of scrutiny of risks

MG confirmed that there had been on-going work through the Governing Body development sessions around the CCGs strategic objectives. MG stated that once the strategic objectives had been agreed then the Board Assurance Framework can be created. MG stated that a template had been agreed for the Risk Register through the Governing Body development sessions. MG stated that Quality & Safety had initially been used to populate the template. It was noted that a meeting had been arranged to align risks to appropriate sub-committees. MG stated that training around the new process was now underway.

JO and PR raised concerns regarding the clarity around the scoring matrix for the risks and requested that some clarity be made as to whether a 4x4 or 5x5 matrix was being used. MB confirmed that the matrix is indeed 5x5. It was asked by the committee that the scoring

contained within the risk dashboard be recalculated to be effective as a 5x5 scoring matrix. It was also requested by the committee that the description reference be incorporated within the scoring matrix to enable the reader to cross reference the numbered risks. It was also noted that it would be beneficial to able to track any changes to risks or those that have been escalated.

MG wished to highlight that throughout Appendix 1 of the report there is further narrative of the progress of individually scored risks and the background to each individual risk.

6.7 Equality & Diversity Quarterly Report

Juliet Herbert was in attendance to provide an update on the Equality and Inclusion support for the CCG October 2016 to February 2017. JH highlighted from the report the on-going work with regard to EDS2. JH clarified for the committee that EDS2 was to help local NHS organisations, in discussion with local partners, people and stakeholders, to review and improve their performance for people with characteristics protected by the Equality Act 2010. JH added that by using EDS2, NHS organisations would also be helped to deliver on the public sector equality duty (PSED).

JH stated that at the heart of the EDS2 were 18 outcomes, against which NHS organisations assessed and graded themselves. JH added that these outcomes related to issues that matter to people who use, and work in, the NHS. They had been grouped under four goals:

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

JH stated as part of this work the CCG had been required to provide sufficient evidence that it was meeting the necessary criteria as detailed above. JH confirmed she had been in the process of populating the EDS2 template with the necessary evidence. JH reported that sign off and an agreed grading would be ready for the Governing Body in March 2017.

7. ITEMS FOR CONSIDERATION

7.1 Patient Stories

No Patient Stories were discussed by the committee.

8. POLICIES FOR CONSIDERATION

8.1 Volunteer Policy

******In the essence of time management at the meeting the chair requested that all comments for this item be circulated via Philip.strickland@nhs.net by Close of Business on Friday the 17th February 2017 for review at the next meeting******

9. ITEMS FOR ESCALATION/FEEDBACK TO CCG GOVERNING BODY

No items were raised by the Committee.

10. ANY OTHER BUSINESS

In the essence of time management at the meeting the chair requested that all comments be circulated via Philip.strickland@nhs.net by Close of Business on Friday the 17th February 2017 for review at the next meeting

11. DATE AND TIME OF NEXT MEETING

- *Tuesday 14th March 2017, 10.30am – 12.30pm; CCG Main Meeting Room.*

This page is intentionally left blank

Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
COMMISSIONING COMMITTEE

Minutes of the Commissioning Committee Meeting held on Thursday 23rd February 2017 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	No
Claire Skidmore	Chief Financial Officer	Yes
Manjeet Garcha	Executive Director Nursing & Quality	No
Juliet Grainger	Public Health Commissioning Manager	Yes
Paul Smith	Interim Head of Commissioning - WCC	Yes

In Attendance ~

Vic Middlemiss	Head of Contracting & Procurement	Yes
Liz Hull	Administrative Officer	Yes

Apologies for absence ~

Apologies were submitted on behalf of Steven Marshall and Manjeet Garcha.

Declarations of Interest

CCM560 None.

RESOLVED: That the above is noted.

Minutes

CCM561 The minutes of the last Committee, which took place on Thursday 26th January 2017, were approved.

RESOLVED: That the above is noted.

Matters Arising

CCM562 None.

RESOLVED: That the above is noted.

Committee Action Points

CCM563 (CCM551) Contracting & Procurement Update – Lessons Learnt Working Session: Discussions have commenced and the working session will be set up to review lessons learnt from contract negotiations to ensure consistency and collaborative working with Wolverhampton City Council.

(CCM555) Heart Failure Service Specification – Dr Morgans reported a misunderstanding and clarified that the CCG is not reorganising the whole Heart Failure Service. Members of the Committee are to clarify this if they are approached.

(CCM557) Risks – It was confirmed that Review of Risks has been included as a standing agenda item going forward. Action closed.

RESOLVED: That the above is noted.

Contract & Procurement Report

CCM564 Vic Middlemiss presented the Committee with an overview and update of key contractual issues in relation to Month 8 (November) for activity and finance. An update was also included with regards to 2017/18 and 2018/19 contract negotiations.

Royal Wolverhampton Trust

CQUIN targets – Discussions are taking place with the Trust regarding Q3 milestones.

Ambulance Handovers – There has been a large increase in the number of breaches. A formal letter has been sent to the Trust about this, with a request for outline business cases to demonstrate how they will re-invest money withheld by the CCG, to improve outcomes. Vic Middlemiss reported resistance by RWT in relation to this.

RESOLUTION: Claire Skidmore to raise the issue with Kevin Stringer.

Contract Negotiations Summary from January Report – Vic Middlemiss reminded the Committee that this section of the report was not included in the January update. Following an exchange of letters in early January, a signed contract was returned to the CCG on 6th January and the risk/ gain share agreement will now be completed over Q4. The offer letter forms part of the contract documentation, with key aspects included as follows:

1. The total value of the contract for 2017/18 (including CQUIN) is £328.7m and £336m for 2018/19. This includes a maximum non-recurrent sum of £1.1m for two years which is for the duration of this contract period only. This is provided as transitional support to the Trust as it embraces its cost reduction challenge.
2. An agreed approach for a 'Risk and Gain Share' in order to address the commonly shared financial challenges that aims to prevent financial destabilisation of the health and social care economy as a whole.
3. A structured programme of dialogue and discussion with regard to the FY 2018/19 which will deliver a financial outcome acceptable to both organisations. This will be complete by 1st February 2018 in order to build into the contract as a variation.

RESOLVED: That the above is noted.

Services Decommissioned (Breast Feeding) – As part of the contract negotiation discussions, it was agreed that the CCG would disinvest in the Breastfeeding Project at the Trust, as of 31st March 2017.

Juliet Grainger advised the Committee that this has created some issues for Public Health, who are still in contract with RWT for a service that is not viable and consequently, this will impact on Public Health outcome for the City of Wolverhampton.

RESOLUTION: Claire Skidmore to feedback lessons learnt from this unintended consequence, to Steven Marshall.

Vic Middlemiss to pick this up as part of the lessons learnt working session to be organised with Public Health.

Black Country Partnership Foundation Trust

Contract Negotiation Update – Negotiations concluded with the Trust in December and an offer letter was sent to the Trust which included:

1. The contracted amount for Older Adults Day Services will remain unaltered and the plan to remodel the service will be detailed in the SDIP.
2. Following the closure of Pond Lane Hospital, the CCG has agreed a block contract for two Learning Disability Assessment and Treatment beds, whilst a third bed will be contracted on a cost and volume basis.
3. The CCG will disburse a non-recurrent sum of £375,000 for special observations (for 2017/18 and 2018/19). This will entail an agreed work plan

regarding the reasons for special observations, which will also form part of the SDIP.

4. The above translates to a financial offer across all four divisions of:
    - £29,534,970 for FY 2017/18
    - £29,343,004 for FY 2018/19.

Associate Commissioner Arrangements - The Committee was reminded of a previous proposal from the City of Wolverhampton Council to become an associate to the contract that the CCG holds with Black Country Partnership Foundation Trust (BCPFT). This request has already been approved by the Council's Cabinet and the CCG has agreed, in principle, to this request, which is also supported by BCPFT subject to executive approval.

RESOLVED: The Committee agreed to support the recommendation made.

Fines/ sanctions – A decision has been made in conjunction with Sandwell and West Birmingham CCG, that sanctions should be applied so that the Trust is treated the same as any acute provider. This will apply from Q3 for any performance breaches and a sanctions tracker submitted to future Contract Review Meetings.

RESOLVED: That the above is noted.

Nuffield

Contract Negotiations – It was confirmed that negotiations have now concluded.

RESOLVED: That the above is noted.

Contract Extensions and Renewals

The CCG has been working with the four Programme Boards regarding service contract end dates. This is to ensure that when contracts come to an end, they are not rolled over without a review process taking place. This will ensure compliance with procurement regulations.

RESOLVED: That the above is noted.

Urgent Care Centre

A contract performance notice has been issued to the Urgent Care Centre provider, Vocare Limited, following a number of issues of significant concerns:

- Safeguarding (concerns about Vocare's staff not having the adequate level of training)
- Failure to complete outstanding actions initially raised in correspondence dated 1st December 2016
- Repeated failure to provide fully completed monthly contract review documentation in the contractually agreed format
- Concerns about quality and the accuracy of data submitted

A remedial action plan has been requested from Vocare.

RESOLVED: That the above is noted.

Review of Risks

CCM565 The Committee was advised that work in relation to Committees reviewing risks is not yet complete. It is intended to complete this by the end of March.

RESOLVED: That the above is noted.

Date and Venue of Next Meeting

CCM566 Thursday 23rd February 2017, CCG Main Meeting Room

RESOLVED: That the above is noted.

This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

Minutes of the meeting held on 28th February 2017
Science Park, Wolverhampton

Present:

Mr P Price	Independent Committee Member (Chair)
Mr J Oatridge	Independent Committee Member
Mrs C Skidmore	Chief Finance and Operating Officer
Mr S Marshall	Director of Strategy and Transformation
Mr M Hastings	Associate Director of Operations

In regular attendance:

Mr V Middlemiss	Head of Contracting and Procurement
Mr G Bahia	Business and Operations Manager

In attendance

Mrs H Pidoux	Administrative Team Manager
Mr M Duhra	Contract Portfolio Manager

1. Apologies

Apologies were submitted by Dr Bush and Mrs Sawrey

2. Declarations of Interest

FP.133 There were no declarations of interest.

3. Minutes of the last meetings held on 31st January 2017

FP.134 The minutes of the last meeting were agreed as a correct record.

4. Resolution Log

FP.135

- Item 99 (FP.16.126) – Mrs Skidmore to contact Mr Oatridge if there is a need to raise issue with NHSPC invoices at the Audit Chair's Conference in March – Mrs Skidmore confirmed that this was not required – action closed.
- Item 100 (FP.16.127) – Consideration to be given to how the key areas of performance are reported to Governing Body - work is in progress and it was agreed to revise the deadline to the end of March 17.

- Item 101 (FP.16.127) – Breakdown of achievement of level 3 and 4 Safeguarding training to be included in the next report - dashboard included in Performance Report on agenda – assurance was taken that training is taking place and standards are at the levels expected. It was asked that it would be highlighted to the Committee if there is deterioration in the future – action closed.

  Assurance was given that this is closely monitored and any concerns are discussed at the Clinical Quality Review meeting (CQRM). Further discussion took place around which committee should be taking the lead on ensuring safeguarding training is taking place. Mr Hastings reported that this is discussed in detail at the Quality and Safety Committee and that the responsibility for this area lies with the Quality and Risk Team. Mr Oatridge commented that it had been noted during these discussions that the GP and Nurse Lead for Safeguarding had left their roles. It was agreed to review the minutes of the Quality and Safety Committee to check the level of discussion and any actions agreed. It was felt that a decision needs to be taken as to which committee takes the lead to ensure a consistency of understanding.

  It was noted that there were no figures contained in the report relating to Board level staff at RWT. It was agreed to check if it was a case that the figures are not available or if the training has not been completed.

Mr Middlemiss joined the meeting

5. Matters Arising from the minutes of the meeting held on 31st January 2017

FP.136 There were no matters arising from the previous minutes.

6. Monthly Contract and Procurement Report

FP.137 Mr Middlemiss presented this report based on Month 9 and highlighted the following key points;

Royal WolverhamptonTrust (RWT)

- A new process is to be introduced to strengthen the level of assurance given to this Committee, Commissioning Committee and the Governing Body. An exception report is to be requested for any performance indicator which is off trajectory. The report will need to include the reason for the deterioration and any actions in place to address this.
- Sanctions – an unusual spike in ambulance handover breaches has been seen which has led to sanctions by the CCG of £85k. RWT report that the batching of ambulances is impacting on performance.

- Business cases are required from RWT to support reinvestment back into the Trust as agreed in the year-end settlement included for MRET, Readmissions and fines/sanctions forecast for year-end. These are required prior to the end of the 2016/17 financial year and are intended to clearly specify how the money will be used and how it will improve outcomes. RWT are pushing in back on this but the CCG is holding the line on requesting the cases be completed.
- 2017/19 Contract – transition arrangements – there are issues to be finalised post contract signature and to be agreed in Quarter 4. A significant area is the Service Development Improvement Plan (SDIP). Agreement was reached to carry over a number of schemes from 2016/17 to 2017/18. A draft was sent to the Trust mid-January, a response was delayed from the Trust due to operational issues. This has now been received and is being considered internally by the CCG.
- Risk Share principles are being agreed at Executive Level. Mrs Skidmore confirmed that she and Mr Marshall are meeting weekly with RWT executives. The Committee was informed that this related to the cost reduction to be made by the Trust through QIPP schemes. Money has been ring fenced in the new two year plan for change in the system for community models. Evidence of cost restructure is required.

Black Country Partnership Foundation Trust (BCPFT)

- Sanctions have been applied since Quarter 3
- Significant improvements have occurred in safeguarding training and the introduction of e-learning. It has been agreed to close the Remedial Action Plan (RAP) due to the continued improvement.
- The national target for the Flu Vaccine CQUIN has not been met; therefore, payment will not be made for this. It was agreed to check with the Quality Team regarding the perceived clinical risk of not achieving this target.

Nuffield

- There is an issue regarding Procedures of Limited Clinical Value (POLCV) and that they may not be following procedure as their conversion rate from referral to treatment is 100%. An audit is due to take place to ensure they are following procedure.
- Referral Diversion – the CCG is expecting activity to increase at Nuffield for Laparoscopic Cholecystectomies and other procedures following the work being undertaken on referral diversion. RWT have agreed to divert patients from their ‘lap coly’ waiting list to Nuffield and this work is currently in progress.

This work is on-going and the impact on activity is being monitored accordingly.

Other Contracts/Significant Contract Issues

- Contract extensions and renewals – an appendix of the report was considered which give the latest position of contracts. Work has been undertaken through the four Programme Boards to review the end dates of service contracts. This is to ensure that there is a timely review process taking place to comply with procurement regulations.

  The outcome of this is also being used to inform discussions with the Commissioning Support Unit (CSU) regarding the CCG's procurement programme for 2017/18 to ensure the required level of support is being planned accordingly.

  The effect of Brexit on procurement was raised as a concern. It was agreed that there is a risk element however the level of this is unknown at present.

- Urgent Care Centre – a contract performance notice has been issued to the provider, Vocare Limited and the appropriate levers used, following a number of issues of significant concern;
  - Safeguarding (concerns about Vocare's staff not having the adequate level of training)
  - Failure to complete outstanding actions initially raised in correspondence dated 1st December
  - Repeated failure to provide fully completed monthly contract review documentation in the contractually agreed format
  - Concerns about quality/ accuracy of data submitted

  A meeting has been arranged between CCG's Chief Officer and Executive Director of Nursing and Quality and the relevant executives at Vocare to discuss the situation.

  As previously reported the CCG has undertaken an analysis of activity and identified that Vocare is significantly under plan for activity year to date, particularly for face to face contacts. The CCG is therefore seeking to claim money back, as per the wording of the contract which states that a 40% marginal rate will apply to activity below a 10% tolerance. Vocare were advised of this in writing in September. Vocare is contesting the decision to take money off them due to under-performance, on the basis that diversion of activity from A&E is only partially within their control, that their staffing costs have not reduced due to lower activity levels and that 16/17 was intended to be a transition year.

The Committee was asked to support the implementation of the claw back of money. It was noted that there is a risk of damaging a good relationship, however, it is important to show that the CCG is serious about using levers to improve performance. The support of the Committee was given.

Mr Price had raised queries outside the meeting relating to the Finance Report, these were discussed at this point of the meeting to allow Mr Middlemiss to feedback as follows;

- Outstanding data queries – it was confirmed that a response had been received from RWT however this was not considered adequate. This has been added to the Contract Review Meeting Query Log and the Trust has been asked to give a fuller response. If this is not deemed sufficient this will be escalated to a more formal response.
- A&E coding – the Trust has reported that winter pressures have meant that this query was not responded to. The Trust has agreed to audit the data as requested by the CCG.
- Troponin pathway – a query was raised as benchmarking has shown the Trust to be an outlier and this needs to be understood. The response received from the Trust was not satisfactory and this has been pushed back.

Resolved – The Committee:

- noted the contents of the report and actions being taken.
- Supported the claw back of money relating to Vocare performing significantly under-plan for activity year to date.

Vic Middlemiss left the meeting

7. Finance Report

FP.138 Mrs Skidmore reported on the Month 9 financial position and stated that the CCG is still on track to achieve financial targets. The key highlights of the report were;

- Achieving targets for recurring and non recurring money is still a challenge. There is a slight deterioration in the recurrent position. This is not materially impacting at present and is being closely monitored as any impact will roll into 2017/18.
- There is headroom in non-recurrent spend and plans are being drawn up to spend this.

- Plans to spend money becoming available to the CCG at year end are being explored. However it is necessary to consider that this is non-recurring and therefore cannot be used to support recurring costs which limits the options to spend.
- QIPP is slightly above trajectory The focus is now on plans for 2017/18. A revised plan has shown that the unallocated QIPP for next year has reduced from £2.9m to £2.6m.
- The details of the unwinding of a 2014/15 accrual were clarified.

- A query was raised regarding the vacancies in Safeguarding. It was confirmed that this related to two administrative posts to support the (Multi Agency Safeguarding Hub) MASH. The successful applicants have recently started in post. The delay in commencement was due to the required for advanced vetting and barring checks which were required before commencement due to the nature of the roles.
- Mr Oatridge queried the amount allocated in running costs to the nursing directorate. It was clarified that this relates to the Continuing Health Care Manager role and the managerial nature of the role. The clinical aspect of the role, the majority of the role, is picked up in programme costs.
- The costs of contracted out services were highlighted, CSU and other costs, and it was agreed that a detailed briefing would be brought to a private session of the next Committee meeting due to the commercial in confidence nature of the information.
- It was asked that clarification be sought regarding the content of the Drugs Volume Comparison table, as to whether this is the number of items prescribed or the number of prescriptions issued.

Mrs Skidmore informed the Committee of an invoice for £4.8m which has been issued by RWT in relation to Physician A. The CCG does not recognise this invoice and Mrs Skidmore has written to the Director of Finance at RWT stating that it will not be paid, no response has been received. It was noted that the contract with RWT has already been signed and this cost was not agreed in the contract.

The issue has been escalated to NHS England's (NHSE) Regional Director of Finance and NHS Improvement (NHSI). The CCG has been advised to complete formal arbitration paperwork by Friday 3rd March, although clarification is awaited that this is the process to be followed.

This issue has been raised with the CCG's external auditors. They are not concerned at this stage. The CCG will keep them up to date with developments in this area.

The Committee noted the current situation and will receive updates as necessary. This will be escalated to the Governing Body if it becomes appropriate to do so.

Resolved: The Committee;

- Noted the contents of the report and the current position.
- Briefing to private session of next Committee regarding the costs of contracted out services.
- Clarification sought re the content of the Drugs Volume Comparison table in report.
- Noted the current situation of the Invoice issued by RWT which the CCG does not accept.

8. Monthly Performance Report

FP.139 Mr Bahia highlighted that of the indicators for Month 9, 43 are green rated, 26 are red rated, 23 have no submissions and 2 are awaiting target.

The following key points from the report were discussed;

- RTT - continues to fail to meet headline. Further performance for the number of outpatients who did not attend is the 3rd highest in the region; work is on-going to address this. A review is taking place of the number of discharges that are made without a procedure taking place. It is being assessed as to whether these patients are progressing through the system correctly.
- Diagnostics – over the last few months performance has deteriorated. The Trust stated that this was due to capacity issues over the Christmas and New Year period and held additional sessions in January to facilitate performance improvements. However, this has not been reflected in January's performance. This will be monitored into February and if improvement is not seen a Remedial Action Plan will be requested.
- A&E – performance compares comparatively well regionally and nationally. However, performance has dropped significantly in January. The A&E Delivery Board has taken decisions to aid recovery for quarter 1 in 2017/18 and continues to maintain an overview of the system. Sanctions have been applied.
- 62 day cancer waits – remains below target which is reflective of the position regionally. A visit was made by the Intensive Support Team (IST) and all of their recommendations were implemented. The Trust has requested further recommendations to improve from NHSI and additional support from the IST. Additional Saturday clinics for Urology have been scheduled. It is anticipated that performance will fall before it improves. A localised

cancer campaign which commenced in February may also impact on performance.

- Waits over 62 days, from referral to first definitive treatment for all cancers – this is a very small cohort of patients. Only 1 patient breached and this was due to the patient being unfit to continue with the planned surgery.
- Zero tolerance RRT waits over 52 weeks – ahead of the Orthodontic trajectory planned by end of the year. The cohort includes 1 complex case which will take longer to complete
- EIS Referrals – small cohort of patients. 1 out of 10 patients not seen due to the patient failing to attend appointment.
- C Diff – although this target has already been breached for the year there is an improving trend.
- Breast Cancer waits – the performance for this indictor is consistently above target.
- IAPTS – national standards are being met. There is a significant improvement compared to last year.

It was noted that the updates given reflect the agenda of discussions with NHSE as agreed at the last Committee meeting.

Resolved: The Committee

- Noted the content of the report

9. HMRC taxation changes effective from April 2017

FP.140 Mrs Skidmore informed the Committee that this briefing had been shared to advise members of changes in taxation coming into effect in April 2017 and the effect on the CCG and its employees. The Finance Team will be working with external agencies (including HR and Payroll teams) to ensure the legislation is complied with. The key points of the briefing were;

- Salary Sacrifice Schemes – the only scheme the CCG currently offers is for childcare vouchers and, therefore, will not see any impact of the new legislation under the current arrangements.
- Apprenticeship Levy – may be eligible to be part of this, if the CCG is, work will need to be completed to assess the requirements to set this up.
- Off Payroll Workers (IR35 amended legislation) – where this legislation applies, the responsibility for PAYE and accounting for income tax and national insurance will fall on the CCG. An on-line toolkit is to be produced by HMRC, however, this is not yet available.
- Managers will need to be aware of the new legislation and advised to review the status of any off-payroll engagements. In particular, any arrangements directly with an individual rather than through an agency should be reviewed as a matter of urgency and potentially individuals will need to be moved onto

the payroll. The new rules apply to payments made on or after 6 April 2017. Once the toolkit from HMRC is available this information will be shared with the Senior Management Team

Resolved – The Committee,

- noted the content of the report
- took assurance that the new rules are being considered to ensure they are complied with.

11. Any Other Business

FP.141 There were no items raised under any other business.

12. Date and time of next meeting

FP.142 Tuesday 28th March 2017 at 3.15pm, CCG Main Meeting Room

Signed:

Dated:

This page is intentionally left blank

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE JOINT COMMISSIONING COMMITTEE

Minutes of the Primary Care Joint Commissioning Committee Meeting (Public)
Held on Tuesday 7th February 2017, Commencing at 2.00 pm in the in the Stephenson Room, 1st Floor, Technology 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	Yes
Manjeet Garcha	Executive Lead Nurse	No
Peter Price	Lay Member (Vice Chair)	Yes

NHS England ~

Alastair McIntyre	Locality Director	No
Gill Shelley	Senior Contract Manager (Primary Care)	Yes
Anna Nicholls	Contract Manager (Primary Care)	Yes
Karen Payton	Senior Finance Manager (Primary Care)	Yes

Independent Patient Representatives ~

Jenny Spencer	Independent Patient Representative	Yes
Sarah Gaytten	Independent Patient Representative	Yes

Non-Voting Observers ~

Ros Jervis	Service Director Public Health and Wellbeing	No
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)	Yes
Claire Skidmore	Chief Finance and Operating Officer (WCCG)	Yes
Helen Hibbs	Chief Accountable Officer	No
Sarah Southall	Head of Primary Care	Yes
Laura Russell	Primary Care PMO Administrator (WCCG)	Yes

Welcome and Introductions

PCC297 Ms Roberts welcomed attendees to the meeting and introductions took place.

Apologies for absence

PCC298 Apologies were submitted on behalf of Dr Helen Hibbs, Alastair McIntyre, Manjeet Garcha and Jeff Blankley.

Declarations of Interest

PCC299 Dr Kainth declared that, as GPs they had a standing interest in all items related to primary care.

Ms Gaytten and Ms Spencer declared that, in their role as employees of the University of Wolverhampton, they worked closely with practices to arrange placements for student nurses and therefore had a standing interest in items related to primary care.

As these declarations did not constitute a conflict of interest, all participants remained in the meeting whilst these items were discussed.

RESOLVED: That the above is noted.

Minutes of the Meeting Held on 3rd January 2017

PCC300 RESOLVED:

That the minutes of the previous meeting held on 3rd January 2017 were approved as an accurate record.

Matters arising from the minutes

PCC301 There were no matters arising from the minutes.

RESOLVED: That the above is noted.

Committee Action Points

PCC302 **Minute Number PCC176 – Premises Charges (Market Rent Reimbursement)**

Ms Payton informed the Committee the National Team have developed local process and procedures. The application will be sent from The NHS England's Premises Team for circulation and should be returned to them once completed.

Minute Number PCC302 – Premises Charges (Rent Reimbursement)
Awaiting the new cost directives to provide clarity on rent reimbursement in relation to when Practices allow other service providers to be use their rooms such as midwives.

Minute Number PCC186a – NHS England Update – Primary Care Update
Mr Hastings confirmed the CCG Primary Care Commissioning Activity return had been shared with the Committee on the 4th January 2017.

Minute Number PCC211 - Vertical Integration
Mr Hastings shared with the Committee the VI assurance visit minutes on the 4th January 2017 and stated there had been a further meeting on the 31st January 2017.

Minute Number PCC283 – Wolverhampton CCG Update
Ms Southall confirmed an evaluation report on the two extended opening hours scheme will be provided at the March and May Committee Meetings.

RESOLVED: That the above is noted.

NHS England Update – Primary Care Update

PCC303 Ms Shelley advised the Committee they receive their updates from the Regional and National Team and no updates have been provided.

Ms Shelley stated the contract changes have been agreed between NHS Employers and the General Practitioners Committee (GPC) and will be published shortly. There a number of changes within the contract in particular the following;

1. The Avoiding Unplanned Admissions (AUA) will be abolished.
2. Extended hours will only be offered to those Practices who do not close on the afternoon. This will take effect from October 2017.

Discussions took place on how extended hours will affect those groups of practices who are starting to work collaboratively, if an individual practice did not work afternoons. It was highlighted at present this is very high level and further detail will follow shortly.

RESOLVED: That the above is noted.

NHS England Finance Update

PCC304 Ms Payton informed the Committee there was no update at present as they are working through the month 10 position and a report will be provided at the next meeting.

RESOLUTION: Month 10 position to be provided at the March Meeting.

Wolverhampton CCG Update

PCC305 Mrs Southall provided the following update on the work being progressed within Primary Care;

- The Members meeting had taken place on 25th January 2017 where an update was given on the group working being undertaken. This included an update on VI and a joint presentation from Primary Care Home 1 and 2 regarding how they are moving towards working on scale. An update was also provided on the work progressing with the Medical Chamber Model.
- The General Practice Five Year Forward Plan for the CCG has been submitted to NHS England. The implementation on plan on how this will be delivered will be shared at the March meeting.
- Conclusion on WIFI access and recognition has been received Nationally as the CCG is one of the first in the Country to roll out within Practices and Communities.
- There are two practices who are undertaking the GP Practice resilience Programme and the Memorandum of Understanding is currently being discussed between the Provider and the Practice.
- Expressions of Interest for the Time for Care Programme are currently being received.
- Reception and Admin Training funding has been received with the aim to develop a 3 year programme with the initial session starting in March 2017.

RESOLUTION: Mrs Southall to provide the General Practice Five Year Forward Plan to the March Meeting.

Primary Care Programme Board Update

PCC306 Ms Roberts shared the report on behalf of Manjeet Garcha in her absence and asked if the Committee had any questions.

It was asked if the Social Prescribing Service would be signposting from clinics as well as Practices. It was confirmed it's currently from GP Practices.

Discussions took place regarding Community Equipment Procurement as at the PPG and Citizens Forum patients were confused as what was included under

community equipment. It was advised this was a joint procurement with the City Of Wolverhampton Council and it covered all equipment.

RESOLVED: That the above is noted.

Primary Care Operational Management Group Meeting

PCC307 Mr Hastings presented the Primary Care Operational Management Group report which provides an overview of the discussions that have taken place at their meeting on the 23rd January 2017. The following items were reported upon;

- An update was provided on the GP Five Year Forward View training programme and it was highlighted a Band 7 role will be recruited to support the programme of work going forward.
- A team has been established to support the Practices to help patients to sign up to online access.
- The collaborative contract review visit programme continues and positive feedback has been received from the Practices.
- The revised Zero Tolerance Specification written jointly with the CCG and NHS England was shared and discussed.
- An update was provided on full delegation a number of handover meetings have been taking place with NHS England to ensure the CCG are ready for full delegation from the 1st April 2017. Mr McKenzie highlighted a report will need to come to the March Meeting outlining the agreement which sets out the powers formally delegated to the CCG and those that have been reserved by NHS England.

RESOLUTION: Mr McKenzie to provide a report to the March Meeting on the full delegation agreement as this will need formal sign off by the Committee.

Any Other Business

PCC308 There were no further discussion items raised by Committee.

RESOLVED: That the above is noted.

PCC309 **Date, Time & Venue of Next Committee Meeting**
Tuesday 7th March 2018 at 2.00pm in the Stephenson Room, 1st Floor, Technology Centre, Wolverhampton Science Park

This page is intentionally left blank

Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
Minutes of the Primary Care Strategy Committee
Held on Wednesday 8th February 2017
Commencing at 12.30pm in the CCG Main Meeting Room, Wolverhampton Science Park, Glaisher Drive, Wolverhampton

Present:

Sarah Southall	Head of Primary Care, Wolverhampton CCG (Vice Chair)
Mike Hastings	Associate Director of Operations, WCCG
Claire Skidmore	Chief Finance and Operating Officer
Jane Worton	Primary Care Liaison Manager, WCCG
Tally Kalea	Commissioning Operations Manager, WCCG
Dr Kainth	Locality Lead, WCCG
Stephen Cook	Senior IM&T Project Manager
Dr Reehana	Locality Lead, WCCG
Ranjit Khular	Primary Care Transformation Manager, WCCG
David Birch	Head of Medicines Optimisation, WCCG
Barry White	Project Manager – New Models of Care (PCH)
Jason Nash	Project Manager - New Models of Care (Unity)
Jane Woolley	PMO Lead, WCCG
Laura Russell (minutes)	Primary Care PMO Administrator, Wolverhampton CCG

Declarations of Interest

PCSC86 Dr Kainth and Dr Reehana declared as GP's their interest they had a standing interest in all items related to primary care.

As Dr Kainth and Dr Reehana declarations did not constitute a conflict of interest, they both remained in the meeting whilst these items were discussed

Apologies for absence

PCSC87 Apologies were submitted on behalf of Sharon Sidhu, Helen Hibbs, Vic Middlemiss, Steven Marshall, Manjeet Garcha and Andrea Smith.

Minutes and Actions

PCSC88 The minutes of the previous meeting held on 11th January 2017 were approved as an accurate record.

The action log was discussed and an updated version will be circulated with the minutes.

RESOLVED: That the above was noted.

Matters Arising

PCSC89 No further items were raised.

RESOLVED: That the above was noted.

Risk Register

PCSC90 **A) Risk Register Report Datix**
Mrs Southall presented the risk register to the Committee and highlighted there were no red risks to escalate to the Committee.

B) Summary of Risk Logs
The risk logs of the following Task and Finish Group were shared with the group;

- Localities as Commissioners
- Primary Care Contract Management
- Capital Review Group/Strategic Estates Forum
- Workforce and Development

Ms Woolley queried the process for risk reporting to ensure all of the Task and Finish Groups were consistent with their reporting. It was agreed each Task and Finish Group need to have their individual risk logs as not all programme risks are scored higher enough to be placed onto Datix, however need to recorded and monitored by the Groups. Those risks which have been agreed as a score 15-25 need to be recorded onto Datix as well as Task and Finish Groups risks which are deemed a high risk but not scoring red (15-25).

RESOLUTION: All Task and Finish Groups need to record all individual risks on their risk logs in order for risks to be recorded and monitored.

Performance

PCSC91 **Implementation Plan**
Ms Russell informed the Committee of the Implementation plan timescales heading has been moved to cover the reporting period from December 2017 to March 2018. The implementation timescales heading will be moved per quarter to provide a more reflective view of the programme of work.

Ms Russell highlighted the following points for the committee to note;

- PCS011 confirmation this piece of work has been completed.
- Practice as Providers (5a) has now commenced and work is being progressed.

Ms Russell highlighted that she continues to meet with the Task and Finish Group Leads to work through the individual plans most of the projects are due to commence from April 2017 and will continued to be monitored.

There were two exceptions reported within the month. The two exception reports were around the following;

- New Models of Care – Relating to EMIS System providing the functions to allow shared records within Primary Care Homes.
- IM&T – Developing of existing text messaging solution.

Once the timescales have been agreed by the Committee then the implementation plans will be updated.

RESOLVED: That the above was noted.

Task and Finish Groups

PCSC92 **Task and Finish Group - Practice as Providers**

Mr Khular informed the Committee the Task and Finish Group Meeting took place on the 17th January 2017 and the following was a summary of the discussions that took place;

Improved Access to Primary Care – meetings have taken place with Primary Care Home and Unity Practices to identify which ten high impact action initiatives would be deliverable over a short, medium and long term. A two year incentive scheme has been developed to deliver this piece of work. Discussions took place around those Practices within vertical integration and ensuring the Practice partners are involved and sighted on this piece of work in order to provide a collective view.

Non-Clinical Support Functions – the schedule will be taken to Primary Care Home and Unity Groups for consideration on their preferred options for provision, the non-clinical functions are:

- Legal services
- Human Resources
- Mandatory Training
- Payroll
- Standardised Policies and Procedures
- Business Intelligence and Data
- Medicines Optimisation and Prescribing Support
- Contract Management
- Procurement of Goods and Services

Mr Birch queried why medicines optimisation had been included as non-clinical, Mr Khular agreed to share his rationale via discussions outside of the meeting with Mr Birch.

Aristotle/Risk Stratification – A risk has been identified at Task and Finish Group level regarding risk stratification as there are concerns that there is limited capacity within the Community Matron service to deliver the input into practice MDTs as specified within the DES and local progression of Risk Stratification. A meeting will be taking place to consider the progress made with Risk Stratification to date and to agree the next steps required to ensure that risk stratification is owned between stakeholders and embedded in practice.

RESOLUTION: Mr Khular agreed to why medicines optimisation had been included as non-clinical function and report back to Mr Birch.

PSCS93 **New Models of Care (Primary Care Home)**

Mr White provided the Committee with the following update on the new models of care progress for Primary Care Home;

- Joint Primary Care Home 1 and 2 meeting took place on the 12th January 2017.
- A Presentation was provided on the Primary Care Home progress to the Members Meeting on the 25th January 2017.
- Service and Pathway development meetings have taken place to agree requirements for Mental Health, Frailty, Clinical Pharmacist and Paediatrics.
- Primary Care Homes Managers Meeting took place on the 17th January 2017.
- EMIS did not go according to plan and an exception report has been provided, however it will not hinder the overall piece of work.
- Primary Care Home 1 and 2 draft documents have been developed such as Caldecott Guardian and Privacy Officer and Information sharing agreements.
- Primary Care Home 1 and 2 groups have agreed to review options for extended access as a collaborative approach.

Mr White presented the Exception Report to the Committee, which outlines the exception against the plan of the New Models of Care project. This is in relation to the Primary Care Home set up and the IT element plan reference number 2.5.1 System Access and Compatibility. The consequences and impact are minimal and actions have been taken to recruit an interim IT Project Manager to support the programme of work. The programme of work was due to be completed by week commencing 6th February 2017 and it is anticipated the work will now complete week ending the 27th February 2017. The Committee noted and agreed the new programme timescales.

RESOLVED: That the above was noted.

PCSC94 **New Models of Care (Medical Chambers)**

Mr Nash provided the following update on the progress made with New Models of Care for the Medical Chambers Group;

- First Unity meeting took place on the 24th January 2017, where they reviewed the Time for Care priorities and they have identified six out of the ten to take forward. It was agreed they would continue to hold monthly meetings.
- Social Prescribing Project Manager will be presenting at the next Unity meeting.
- A clinical pharmacist bid will be submitted the 10th of February 2017, which Intrahealth have offered to act as the employing organisation.
- Extended opening from April has been shared and is being explored in relation to the feasibility of working as smaller groups within localities.
- A visit took place to Erewash CCG to understand their arrangements and how they have moved forward towards MCP.

RESOLVED: That the above was noted.

PSCC95 **Task and Finish Group – Localities as Commissioners**

Mr Khular gave an update to the Committee on the work that is being progressed against the programme of work highlighting the following;

7 Day Working – The CCG's action plan focuses on the relevant clinical standards i.e. patient experience, mental health, transfer to Primary, community and social care plans quality improvements.

Each standard has a series of actions, the Trust (RWT) have a similar plan for the remaining standards and both plans are monitored via the 7 Day Service Monitoring Group with NHS England.

Practices would be required to consider as they provide services i.e. improving access 2017-2019 although recognition was given to some practices who were already offering appointments on Saturdays.

Basket Services Costing Template - This has now been finalised and the template was presented to the Clinical Reference Group on the 24th January and shared with LMC. It will also be going to the Commissioning Committee at the end of the month.

Practice Level Dashboard - These are being developed at a group level, feedback from groups had been encouraged.

Local QOF – A local QOF has been formed and meeting will be taking place on the 2nd February 2017 to review disease/condition specific indicator sets, with a view to developing a series of locality defined indicators.

RESOLVED: That the above was noted.

PSCS96 **Task and Finish Group – Workforce Development**

Mr Khular provided a summary on behalf of Ms Garcha in her absence of the discussions that have taken place at the Workforce and Development Task and Finish Group. The key points highlighted to the Committee were;

- Workforce fayre planning continues with an evening and afternoon session being organised.
- Funding for development of nurse mentors in Primary Care of £30,000 is to be confirmed.
- The Nurse Facilitator from CEPN has now commenced within Primary Care.
- Five GP Practices have been confirmed as student nurse placement sites for University of Wolverhampton with 7 mentors across all the sites.
- There are 4 nurses who have applied for SLAiP mentorship course.
- The risks that were identified are:
  - A lack of suitably qualified mentors resulting in staff having to drop out of courses.
  - Lack of buy in from practices resulting in no support for staff undertaking courses.

It was agreed Mr White and Mr Nash would feedback to the New Models of Care Groupings regarding the risk from the Workforce and Development Task and Finish Group.

RESOLUTION: Mr White and Mr Nash would feedback to the New Models of Care Groupings regarding the risk from the Workforce and Development Task and Finish Group.

PSCS97 **Task and Finish Group – Clinical Pharmacists in Primary Care**

Mr Birch informed the Committee vertical integration and other some other practices within Primary Care Homes have submitted bids for funding new clinical pharmacist roles. The KIP's are being developed and a gap analysis is being recoded on a database which is being updated. Mrs Southall highlighted it would be helpful to know those practices who are not involved within the bidding process.

RESOLVED: That the above was noted.

PSCS98 **Task and Finish - Primary Care Contracting**

Mrs Southall provided the reports update on behalf of Vic Middlemiss and stated that the last meeting took place on the 25th January 2017. The group discussed the membership and the opportunities for shared learning between the Local Authority and CCG. There was an update given on the Primary Care Groupings and the group was made aware of the recently published documentation on MCP contracts. It was highlighted work has been undertaken to complete a state of readiness for bids from a practice groupings point of view, which will help to form commissioning/contracting perspectives.

The Collaborative Contract Review Visit Programme remains on track with three visits now complete with a fourth taking place at the end of February 2017. The feedback has been positive and an evaluation will be undertaken and a report provided at the April Committee Meeting.

RESOLUTION: Collaborative Contract Review Visit Programme Evaluation Report to be shared at the April 2017 meeting.

PSCS99 **Task and Finish Group – Estates Development**

Mr Kalea provided the following overview of the work and discussion taking place against the Estates Programme of work and the key points were noted;

- **Locality Hubs –** the South East Locality hub location is currently under review due to NHS England Property Services contractual issues regarding land ownership.
- **ETTF Bids –** an independent prioritisation exercise is underway and will take 4/6 weeks to complete. This will highlight where the priorities are within Wolverhampton and a paper with recommendations will be taken to relevant Committees and the Governing Body for a decision.
- **Cohort 1 Schemes –** It was reported there is potentially a three month slippage due to the need for lease agreements being signed by each Practice. Ms Skidmore asked if assurance has been sought from NHS England Property Services if they will be ring-fencing the money for these developments, It was confirmed they have provided assurance the funding is secure.

RESOLVED: That the above is noted.

PCSC100 **Task and Finish Group - IM&T Business Intelligence**

Mr Cook provided an update on the IM&T Programme of work and highlighted the following key points;

- The CCG have now received the funds from NHS Digital for early Wi-Fi adopters. Installations have continued across Wolverhampton and the phase one practices went live on the 30th January 2017, in advance of a full go live later in March 2017.
- The EMIS remote consult meeting has taken place and work is being undertaken with the vertical integration project manager to set up meetings to take place to get EMIs online set up within these practices.
- The JAYEX project has started to be rolled across Practices.
- ETTF Bid for 17/18 has been submitted regarding expanding existing shared care record.

Mr Cook presented an exception report on the exception against plan for development of existing Test Messaging Solution. The project has been delayed from the initial start date of the 1st December 2016 until the 1st April 2017. This is due to additional functionality not being available yet through the NHSMail contract with EE. It was highlighted work with partner organisations and suppliers continue to ensure that the solution can be implemented as soon as the functionality is made available via EE and NHSmail. Ms Woolley queried if the

project will still remain as a 32 week project from the 1st April, Mr Cook confirmed it would still continue as a 32 week project.

RESOLVED: That the above is noted.

PCSC101 **GP 5 Year Forward View**

Mrs Southall presented an update on the training programmes associated with the General Practice Forward View and the progress made to date against the programs that have commenced. The CCGs General Practice Forward View Implementation Plan has been developed and shared with NHS England who have rated the plan as an amber/green and have asked the CCG to provide more detail regarding investment. The plan has to be re-submitted the 24th February following sign off by the Executive Team and a final version will be provided at the March Committee Meeting.

RESOLUTION: Final General Practice Forward View Implementation plan will be shared at the March Committee Meeting.

Discussion Items

PCSC102 **A) Evaluation Report PCH Group Working Pilot (Christmas and New Year)**

Mr White informed the Committee that 5 Practices took part in the pilot with a mix of provisions offered at each practice. The final service offered up to 655 GP and 75 nurse appointments over the 5 day period between Christmas and New Year. For the duration of the pilot Practices dealt with 465 patients of which 446 were GP appointments and 19 were for nurse appointments. The breakdown of costs for each practice was outlined by day and the overall scheme covering the 5 practices cost £40, 34.56.

Mr White stated a patient satisfaction survey exercise was undertaken with 138 feedback forms returned out of the 465 patients which showed an positive response. It was highlighted that one of the questions asked "If you did not use this service what would you have done", the responses were as follows;

- Wait for your own GP to open – 44.2%
- Attend A&E – 28.3%
- Ring 111 – 15.9%
- See a pharmacist – 5.1%
- No response – 4.3%
- Other – 2.2%

Discussion took place regarding patient behaviors and of those who would have waited to be seen a GP did they need to be seen and could they be reeducated as to where they can be referred too. It was requested if the GPs could be asked of those patients they did seen if based on their clinical judgment did they really need to be seen by a GP.

RESOLUTION: Mr White to seek feedback from the 5 practices regarding patients they did see within this period and whether in their clinical opinion they did need a GP appointment.

B) Zero Tolerance Specification and Commissioning Intentions

Mrs Southall presented to the Committee the revised service specification in anticipation of the CCG assuming commissioning responsibilities for primary care services from 1st April 2017.

The current service provider's contract is due to end on 31st March as per commissioning arrangements with NHS England.

The new draft service specification has been considered by the Primary Care Operational Management Group in January 2017 and Primary Care Joint Commissioning Committee in February 2017 and agreed in principle, noting that the following subsequent actions were taking place:-

- Seek approval from Primary Care Joint Commissioning Committee to identify a suitable alternative provider of services
- Commence expressions of interest from suitable providers of service(s) given that the value of the scheme is below £20,000 (currently funded by NHS England £15,000) with oversight from the CCG Contracts Team
- Award of contract to a suitable provider will be in line with the CCG and NHS Procurement Rules
- A policy and procedure will also be developed to coincide with the service specification based on NHS England guidance and best practice.

Mrs Southall highlighted the Primary Care Operational Management Group will continue to have oversight of the service and policy as well as receiving assurance on provision and suitability of service provision.

A meeting with the current provider will be taking place to ask if the will continue until the successful bidder has been awarded with the contract.

The Committee acknowledged the revised specification and agreed with the report's recommendations.

RESOLVED: That the above is noted.

Any Other Business

PCSC103 Ms Russell shared with the Committee the revised Committee dates which have been moved to the third Thursday of each month to accommodate the Chairs availability. It was highlighted that reports for meetings going forward need to be sent to Liz Hull who will be collating the papers for the meeting.

RESOLVED: That the above is noted.

Date of next meeting

Thursday 16th March 2017 at 1.00pm – 3.00pm in the CCG Main Meeting Room, Wolverhampton Science Park

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

Minutes - 15 February 2017

Attendance

Members of the Health and Wellbeing Board

Cllr Roger Lawrence	Leader (Chair)
Cllr Paul Singh	Shadow Cabinet Member – Health and Wellbeing
Cllr Paul Sweet	Cabinet Member for Public Health and Wellbeing
Cllr Sandra Samuels OBE	Cabinet Member for Adults
Ros Jervis	Service Director - Public Health and Wellbeing
Linda Sanders,	Strategic Director - People
Robin Morrison	Healthwatch Wolverhampton
Tim Johnson	Strategic Director - Place
Jayne Meir	West Midlands Police
Elizabeth Learoyd	Healthwatch Wolverhampton
Ian Darch	Third Sector Partnership
David Watts	Service Director – Adults
Jeremy Vanes	The Royal Wolverhampton Hospitals NHS Trust
Alan Coe	Chair - Wolverhampton Safeguarding Boards
David Baker	Operations Commander West Midlands Fire Service
Dr Helen Hibbs	Wolverhampton Clinical Commissioning Group
Jo Cadman	Black Country Partnership NHS Foundation Trust

Employees

Andrew Wolverson	Head of Early Intervention
Paul Smith	Interim Manager for Commissioning Older People
Earl Piggott-Smith	Scrutiny Officer
Helen Tambini	Democratic Services Officer

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:

- Helen Child - Third Sector Partnership
- David Loughton - The Royal Wolverhampton Hospitals NHS Trust
- Cllr Val Gibson – Cabinet Member for Children and Young People
- Steven Marshall – Wolverhampton Clinical Commissioning Group

2 **Notification of substitute members (if any)**
Ian Darch attended on behalf of Helen Child.

3 **Declarations of interest (if any)**
There were no declarations of interest.

4 **Minutes of the previous meeting (30 November 2016)**
That the minutes of the meeting held on 30 November 2016 be confirmed as a correct record and signed by the Chair.

5 **Matters arising**
Councillor Sandra Samuels OBE briefed the Board that Wolverhampton had been shortlisted for the Dementia Friendly (City of the year award) and recognised for its work, but did not win the award. The Board acknowledged the good dementia awareness work being done across the city.

6 **Health and Wellbeing Board - Forward Plan 2016/17**
Ros Jervis, Service Director Public Health and Wellbeing, introduced the report. The Board considered the items on the draft agenda for future meetings. The Service Director advised the Board that a small executive group has been set to ensure items are presented in a timely way. The Board discussed the Shropshire and Telford STPs and the implications of the plans for Wolverhampton.

The Board suggested that NHS Capital Programme update report should be presented by a representative of Wolverhampton CCG and not NHS England as stated.

Resolved:
1. The Board approved the updates to the Forward Plan.
2. An update on the specific implications for the Black Country of the Shropshire and Telford STPs to be added to the agenda for the meeting on 29.3.17

7 **Improving outcomes within the early years**
Andrew Wolverson, Head of Early Intervention, gave a presentation about the aims of the Early Years Strategy. The Head of Early Intervention commented that 128 written responses had been received to the consultation and 50 people attended a public consultation event on 17 February 2017.

The Head of Early Intervention added that public feedback on the consultation had highlighted the issue of the need for the document to be more specific about what is needed at early year's level. The Head of Early Intervention commented on the importance of underlying values listed in the report and in particular the role of parents as being first educators and their impact on their child's development.

The Head of Early Intervention explained that the consultation ends on 17 February 2017 and the Board were encouraged to contribute to the discussion about the document.

The Board expressed concern that there was no reference to the issue of mental health and the need to align physical and mental development in early years. The Board supported this change and added the highlighted the importance of good maternal health and supporting mothers who are either depressed or diagnosed with

other mental health issues. The Board commented on the link between post natal depression and a child developing mental health issues in later life.

The Board discussed the importance of strategy signposting people to the services and also raising awareness of the support available.
The Head of Early Intervention commented on the support available at family hubs and the key role of GPs being part of engagement strategy.

The Board commented on the importance of the issue of keeping children safe as being part of the strategy. Alan Coe commented that he would welcome a specific reference in the strategy to the issue of safeguarding. The Board welcomed the reference to the importance of improving perinatal mental health. The Board suggested that the strategy should also include reference to supporting families where drug and alcohol misuse is an issue.

The Head of Early Intervention commented on the support available from the Family Nurse Partnerships to help families in this situation.

Resolved:

1. The Board endorsed the principles and values of Early Years Strategy.
2. The panel comments on the Early Years Strategy to be considered as part of the stakeholder consultation process.

8 **Wolverhampton CCG Operational Plan 2017-19**

Dr Helen Hibbs, Chief Officer, Wolverhampton City Clinical Commissioning Group presented the report. The Chief Officer commented on the key priorities for delivery of the strategy and the six key objectives. The Chief Officer reaffirmed the commitment of the CCG to delivering the objectives in the Black Country Sustainability and Transformation Plan (STP) and the link to the CCG Operational Plan. The Chief Officer commented that the plan has been aligned to other strategic documents, for example, the Health and Wellbeing Board Strategy and the Joint Strategic Needs Assessment.

The Chief Officer commented on the importance of working with partners to deliver the changes.

The Chief Officer added that the plan details risks to delivering the objectives but offered reassurance to the Board about the robustness of the plans. The Board commented that the strategy needs to include reference to the issue of safeguarding children given the importance of the CCG role. The Board commented on the need for active engagement with partners. The Chief Officer responded that the issue safeguarding is taken as a given but accepted the point and agreed to make the issue more explicit in the strategy.

Resolved:

1. The Board comments on the CCG's Operational Plan 2017-19 to be considered and the suggested changes included in a revised draft.
2. The Board agreed to endorse CCG's Operational Plan 2017-19.

9 **Wolverhampton Safeguarding Board Adults Annual Reports 2015 - 2016**

Alan Coe, Independent Chair - Safeguarding Adults Board, introduced the report and explained that presenting the annual report about progress against priorities for 2014-15 to the Health and Wellbeing Board. The Independent Chair commented that

it is statutory requirement to produce an annual report on behalf of the Wolverhampton Safeguarding Adults Board. The Independent Chair commented that safeguarding adults is different than when working with children, as adults are involved in making decisions and they can make unsafe choices.

The Independent Chair encouraged members of the Board to read the full report which details of the progress made and examples of safeguarding initiatives led by partner agencies. The Independent Chair added that Board members are encouraged to say how they contribute to the aims of safeguarding adults and acknowledged the excellent work of West Midlands Fire Service.

The Independent Chair referred to the increase of 29 percent in the number of safeguarding concerns and added that this a reflection of the higher levels of public awareness and concern about the issue. The Independent Chair added that that changes in the remit of the MASH to include adults has also contributed to this increase. The Board is getting more direct referrals from the police. The Independent Chair commented that the more referrals received is a good indicator of the work being done to raise awareness of the issue.

The Independent Chair commented that despite the progress made more work is needed to collect evidence about the extent to which people feel safer as a result of the intervention by a partner agency and their overall experience of the service. The Independent Chair commented that the Council's important safeguarding role is often underplayed and highlighted the work of trading standards service as partnership working in practice, as an example of an excellent service .

Cllr Samuels, Cabinet Member for Adults, welcomed the report and the progress made to improve adult safeguarding arrangements in Wolverhampton.

Resolved:

1. Those members of the Board who also represented on Wolverhampton Safeguarding Adult Board to provide assurance that the annual report 2015-16 findings are considered by their respective organisations.
2. Recommendations 1 and 2 noted.

10 **Public Health & Wellbeing Commissioning Intentions**

Ros Jervis, Service Director - Public Health and Wellbeing, introduced the report. The Service Director advised the Board that in future public health commissioning intentions will be integrated within the commissioning strategy for the People Directorate as a whole, and added that this is very welcome positive step. The Board were advised that the ring fenced grant will end in 2018 to be replaced by local funding arrangements.

The Service Director commented on public health intentions 2017-18 and plans to redesign and retender health protection services to better deal with issues of tuberculosis and infection prevention in more joined up way.

The Board were advised that a wide range of stakeholders were represented on the multi-agency steering group. Paul Smith, Interim Manager for Commissioning, Older People added that a thematic approach has been adopted to take the work forward. As a result of this change it is easier for agencies to learn from each other.

The Board commented that the issue of FGM was not part of the commissioning intention. The Service Director responded that the issue of FGM was specifically part of this work and suggested that it should be picked up by safer partnership work.

Resolved:

1. The Board reviewed and endorsed the commissioning intentions for Public Health and Wellbeing 2017-2018.
2. The Board noted recommendations 1 and 2

11 **Better Care Fund (BCF) : Quarterly Report**

Paul Smith, Interim Manager for Commissioning, Older People, introduced the update report on progress towards the planning process for 2017/18 Better Care Fund (BCF). The Manager for Commissioning advised the Board that work on the plan has been completed but awaiting Government guidance, which has been delayed. The Interim Manager advised the Board that the necessary preparation work continues so that Government submission deadlines are met, when the guidance is published.

The Manager for Commissioning advised the Board that the BCF plan is a two year programme. The BCF is still the delivery model and will complement and not replace existing CCG plans.

The Manager for Commissioning advised the Board that a 'deep dive' is planned for February which will involve partners. The Board commented that the BCF plan needs to look how it will contribute to Strategic Transformation Programme (STP). The Board commented that work being done to review the estates that will support this work.

The Board discussed the use of local pooled budgets to support the achievements of the BCF plan and the challenges to being more productive.

The Board discussed the cost pressures on the health and social care sectors and acknowledged that there is no guaranteed funding. The Board agreed that there was a need to look more radically create the space that can be used to support the transformation.

The Board commented that the plan is aimed at avoiding the need for people to go into hospital. The BCF should be used to transform services. The Board supported the transformation work. The Board commented on the challenges presented by BCF but also acknowledged the potential offered the CCG and the Council.

The Cabinet Member for Public Health and Wellbeing commented on the findings of analysis done on published by the Chartered Institute of Public Finance and Accountancy (CIPFA). The report concluded that some published STPs do not provide a credible case about how the savings target will be achieved. The Cabinet Member expressed concern about the risk of having to make forced savings to meet the target. The Board commented on the delay in publishing guidance on the preparation of STP's and how this has impacted on the work done to date.

The Manager for Commissioning commented on future demographics and the expected growth and the challenge in finding yearly savings. The Manager for

Commissioning added that it was important to have policies aimed at reducing growth in demand for services.

Resolved:

1. The Board agreed to note the progress towards to the planning process for the 2017/18 BCF programme.
2. The Board requested a report on the financial monitoring procedures in place to ensure that a greater integration of services can be delivered, including the identification of efficiencies to fund the demographic growth.

12 **Mental Health Services: Revised Provider Trust Arrangements**

Jo Cadman, Strategy and Transformation Director, introduced the report and gave an overview of the process of the Transforming Care Together (TCT) partnership between the different organisations represented. The Strategy and Transformation Director commented that the partners are looking at ways of improving mental health and learning disability services provided in Wolverhampton.

The Strategy and Transformation Director commented on the work being done with partners in Dudley and Walsall about the benefits of working together.

The Strategy and Transformation Director outlined the next steps in the process and explained that the partners are aiming to have a combined organisation in place by 1 October 2017. The Strategy and Transformation Director added that there is an expectation that the savings will be achieved from combining current back office functions and clinical opportunities in the future.

The Strategy and Transformation Director explained that the proposal fits into the STP and is also aligned with the strategic plans of the CCG and the Council. The Board queried how the proposals fit with the findings of the Mental Health Commission and the specific health work streams. The Strategy and Transformation Director commented that each organisation was developing their individual transformational plans. The information will be shared across the different organisations to check that they meet the local needs.

The Board queried if the possibility of the impact of unintended consequences of the proposal changes have been considered. Alan Coe, Independent Chair - Safeguarding Adults Board, suggested that the impact of combining a number of mental health trusts may have an impact on safeguarding arrangements within the Trust. Alan Coe recommended that a report should go to those Boards that might be affected.

The Strategy and Transformation Director responded that a report on the work is presented to the respective board about the proposals to get a level of reassurance. The Strategy and Transformation Director commented on the current infrastructure and that it would be difficult to service each locality and agreed to look the impact of proposals on resources and current demand.

Resolved

1. The Board comments on the planned integrations to be shared with partners during discussions about the Transforming Care Together partnership document.
2. The Board agreed to receive a further report when Government guidance issued

13 **Exclusion of the press and public**

To pass the following resolution:

Resolved:

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 involved the likely disclosure of exempt information falling within paragraph 3 of Schedule 12A to the Act relating to the business affairs of a particular person.

14 **Transforming Care Programme**

Paul Smith, Interim Manager for Commissioning, Older People, introduced the draft report on the Black Country Transforming Care Partnership plan. The Board were invited to consider and approve the vision and work plan associated with its delivery. The Board was concerned that work on finalising the Black Country Transforming Care Partnership Plan had been delayed pending further guidance and financial clarity from the NHS and those concerns should be raised at the appropriate level. The Board discussed the Board making representations to the LGA about the delay in the Government publishing guidance. The Interim Manager noted the comment.

The Board discussed the report and agreed to note the progress and current actions. The Board agreed to follow up on progress when the Government guidance is published.

Resolved:

1. The Board agreed approve the vision and work plan associated with the delivery of the Black Country Transforming Care Partnership plan.
2. The Board agreed to receive an update report when guidance issued by Government.

This page is intentionally left blank