

**A meeting of the Wolverhampton Clinical Commissioning Group Governing Body**

**will take place on Tuesday 11th July 2017 commencing at 1.00 pm**

**at Wolverhampton Science Park, Stephenson Room**

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		<b>Date and time of next meeting ~</b> Tuesday 12 September 2017 ~ Governing Body Board Meeting		



**WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY**

Minutes of the Governing Body Meeting held on Tuesday 23 May 2017  
Commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

**Attendees ~**

Mr J Oatridge Chairman (Interim)

**Clinical ~**

Dr M Kainth Board Member  
Dr R Rajcholan Board Member

**Management ~**

Dr H Hibbs Chief Officer  
Mr S Marshall Director of Strategy and Transformation  
Ms C Skidmore Chief Finance Officer/Chief Operating Officer

**Lay Members/Consultant**

~  
Mr P Price Lay Member  
Ms P Roberts Lay Member  
Ms H Ryan Lay Member  
Mr L Trigg Lay Member

**In Attendance**

Ms T Cresswell Health Watch representative  
Ms M Court Children's Commissioning Manager  
Ms K Garbutt Administrative Officer  
Mr M Hastings Associate Director of Operations  
Ms R Jervis Public Health  
Mr P McKenzie Corporate Operations Manager  
Mr D Watts Wolverhampton Council

Mr J Oatridge welcomed both Mr Les Trigg and Ms Tracy Cresswell to the Governing Body meeting.

**Apologies for absence**

Apologies were received from Ms M Garcha, Dr D Bush, Dr J Morgans, Dr S Reehana

## **Declarations of Interest**

WCCG.1801 Ms H Ryan declared an interest as Manor Road Practice, the practice where she is based, has expressed an interest in vertical integration.

Mr P McKenzie advised that Dr J Morgans has declared an interest as he has taken on a fixed term contract with Alfred Squire Road practice, with effect from 1 May 2017. Alfred Squire is a vertically integrated practice. Mr McKenzie added a discussion has taken place regarding the course of action to take due to the conflict of interest and Dr Morgan's role as Chair of the Commissioning Committee as well as a Governing Body member. We are in the process of reviewing the Governing Body membership and elections will be taking place in due course. However in the interim in order for this conflict to be managed a second GP will be invited in the interim to the Commissioning Committee and Dr Morgans will be able to withdraw from decisions around the Royal Wolverhampton Trust (RWT) contract

Mr P Price confirmed he is comfortable with this arrangement and this is an appropriate way forward.

RESOLVED: That the Governing Body supported this decision.

## **Minutes**

WCCG.1802 **WCCG.1776 Declarations of Interest**

Ms C Skidmore pointed out for clarity the second paragraph should read "Dr J Morgans declared an interest as he will be carrying out locum cover for maternity leave for the vertical integration arrangement with effect from 1 May 2017"

**WCCG.1783 Audit and Governance Interim Chairing Arrangements**

Ms P Roberts pointed out that Mr Les Trigg is also deputy chair of the Primary Care Committee.

RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group Governing Body meeting held on the 11 April 2017 be approved as a correct record subject to the above amendments.

### **Matters arising from the Minutes**

WCCG.1803            There were no matters arising from the minutes.

RESOLVED: That the above is noted

### **Sign off the accounts and annual report**

WCCG.1804            Ms Skidmore stated that the annual report and accounts are being taken to the private session of the Governing Body. This is not usual practice; however we have been informed by NHS England that due to the purdah constraint this prevents us from dealing with this in the public meeting. Once the general election has taken the documents will be available on the website.

Mr Oatridge pointed out there are no matters of concern with the accounts and a good discussion with the external and internal auditors has taken place. Both have expressed confidence in the numbers given to them.

RESOLVED: That the above is noted.

### **Committee Action Points**

WCCG.1805            RESOLVED: That the progress report against actions requested at previous Board meetings be noted.

### **Chief Officer Report**

WCCG.1806            Dr H Hibbs presented the report. She pointed out the concerns around the Urgent Care Centre run by Vocare. This will continued to be closely monitored.

The Members Meetings was successful with over 30 practices attending. A good discussion had taken place around New Models of Care. The Social Prescribing pilot has now commenced. The Clinical Commissioning Group (CCG) has commissioned the pilot with Wolverhampton Voluntary Sector Council. Three link workers will be working across the City accepting referrals from GPs, Community nursing teams, A&E etc for patients with low level support needs. The link workers work with patients to signpost and support them to improve their wellbeing. Mr Oatridge referred to 2.5.3 Better Care Fund and how this will be integrated into the

Sustainability Transformation Plan. Dr Hibbs stated that this will fall within the work around place based commissioning.

Dr Hibbs stated Wolverhampton Clinical Commissioning Group (WCCG) will be welcoming Tony Gallagher, who is currently the Chief Finance Officer at Walsall CCG. He will split his time between Walsall and Wolverhampton spending 2.5 days in Wolverhampton and will be reporting directly to Dr Hibbs regarding his work in Wolverhampton CCG

She referred to the cyber-attack which took place last week. Our IT service, provided by RWT, was monitored closely. Due to the good mitigation control, no systems in Wolverhampton were affected. Regular updates were received and she thanked Mr Hastings, his team and RWT for their hard work and support around this issue. Mr Oatridge supported this and it was commendable that Wolverhampton did not suffer.

RESOLVED: That the above is noted.

#### **Board Assurance Framework – Quarter 4**

WCCG.1807 Mr Oatridge stated this report has been withdrawn and will be brought back to the Governing Body in July 2017.

RESOLVED: That the above is noted.

#### **Future Commissioning across the Black Country – Terms of Reference Black Country and West Birmingham**

WCCG.1808 Mr McKenzie gave an overview of the report which outlines the proposed governance arrangements for the initial work of Black Country and West Birmingham Commissioning Board including the Terms of Reference for the Governing Body's approval.

Mr Oatridge referred to Appendix 1, Managing Conflicts of Interest. Mr Peter Price will be carrying out this role. Mr L Trigg referred to item 6.2 and requested clarity around "seat at the table" model for specialised commissioning. Dr Hibbs confirmed this is having a say but not holding the budget or decision making at present.

Mr McKenzie pointed out that the Joint Committee Chair will be taken by one of the CCG Chair members and will rotate amongst them every six months in line with a schedule determined by the committee. The Vice Chair of the Joint Committee will be elected from amongst the Chairs who will deputise for the Chair of the Joint Committee as required.

There was discussion around representation as Sandwell and West Birmingham CCG had requested that a finance director and lay member from each CCG should be core members of the joint committee. The Governing Body felt that the original proposal of two Chairs and two lay members with one from each organisation was preferable and easier to manage.

RESOLVED: That the Governing Body approved the Terms of Reference for the Black Country and West Birmingham Commissioning Board, a Joint Committee of Dudley, Sandwell and West Birmingham, Walsall and Wolverhampton CCGs.

Ms M Courts arrived

### **Children's Emotional Health and Wellbeing**

WCCG.1809

Mr Marshall introduced the report; Ms M Courts explained that this is to seek approval to use Children Adolescence Mental Health Services (CAMHS) funds to commission a joint Emotional Mental Health and wellbeing service with the city of Wolverhampton Council for a three year period. Approval was also being sought for the service to be governed under the Better Care Fund via pooled budget arrangements. Ms Courts gave an overview of the report highlighting the key points on page 1. Ms Skidmore clarified that funding has been identified of £100,000 from the additional growth funds available for Child and Adolescent Mental Health Services to support this new service.

Mr D Watts pointed out that equality implications need to be considered. Ms Courts confirmed she will take this back. Dr M Kainth asked if there will be a good triage system at the start. Ms Courts stated that tier 2 and 3 staff will sit together to ensure patients go to the correct place when referrals are received from practices. Tender processing is taking place and this service should start in September 2017. Mr Marshall confirmed that clinicians and social workers have been involved throughout the process.

RESOLVED:

- (1) That the Governing Body approved to use CAMHS funds to commission a joint Emotional Mental health and wellbeing service with Wolverhampton Council for a three year period.
- (2) That the Governing Body approved for the service to be governed under the Better Care Fund via pooled budget arrangements.

Ms Courts left

### **Appointment of Secondary Care Consultant**

WCCG.1810 Mr McKenzie referred to the report which is to advise the Governing Body that, following a recruitment process, Mr Amarbaj Chandock has been appointed to the position of Secondary Car Consultant.

RESOLVED: That the Governing Body agreed to the appointment of Mr Amarbaj Chandock as the Secondary Care Consultant on the Governing Body.

### **Committee Annual Reports**

WCCG.1811 Mr P McKenzie stated this is to introduce the annual reports of the Governing Body Committees that demonstrate how each of them has met their terms of reference as set out in the CCG's Constitution. Mr Oatridge added that a discussion has taken place and there are a few cosmetic changes which Mr McKenzie will resolve.

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

### **Commissioning Committee**

WCCG.1812 Mr Marshall presented the report. It was pointed out that Relate have been offered a six month pilot contract to provide life counseling regarding debt/relationship management. GPs will be carrying out the referrals into this and will start in May 2017. Ms Ryan reported she has not received any details regarding this service. Mr Marshall will follow this up.

RESOLVED: That the above is noted.

### **Quality and Safety Committee**

WCCG.1813 Dr R Rajcholan introduced the paper. She pointed out that following a rigorous application process, the Point of Care foundation review panel has selected WCCG's quality team as one of the Patient and Family Centres Care 'Living Well to the Very End' programme sites.

Dr Rajcholan pointed out one Never Event was reported in April 2017. Failure to remove a guide wire at time of insertion of a chest drain. Contributed factors and action plans are in place and a full update will be provided.



Ms Ryan mentioned that there is currently up to a 13 week wait for a MRI result and asked if there is any guidance. The quality team is aware of the problem and Steven Forsyth is carrying out work around this and the Governing Body will be kept informed.

Mr Watts expressed concern regarding unsafe discharges. Dr Rajcholan stated work has been carried out around falls and there are issues regarding social issues relating to transfer of care. She will speak to Ms Manjeet Garcha and provide further information to Mr Watts.

Mr Hastings pointed out that the enhanced Infection Prevention audit in practices will be implemented in shadow format immediately. At the end of the year a report will be submitted giving assessments. He confirmed he will provide details requested by Ms Ryan in order for her to update her practice.

RESOLVED: That the above is noted.

### **Finance and Performance Committee**

WCCG.1814 Ms Skidmore gave an overview of the report. At month 11 we are still on track to deliver our control totals. Exceptions are highlighted in the body of the report. She gave an update on contracting stating the contract meeting needs to be more robust. There will be inviting RWT to present to us.

RESOLVED: That the above is noted.

### **Audit and Governance Committee**

WCCG.1815 Mr Oatridge gave a brief overview of the report.

RESOLVED: That the above is noted.

### **Primary Care Joint Commissioning Committee**

WCCG.1816 Ms Roberts gave an overview of the report. She pointed out that under 2.2.2 a word is missing. It should read "the Committee noted that discussions have taken place around the Collaborative Contract Review Pilot visit".

RESOLVED: That the above is noted.

### **Primary Care Strategy Committee**

WCCG.1817 Mr Marshall presented the report highlighting the General Practice Forward View on page 9 of the report. Mr Oatridge pointed out that the task and finish group priorities –

- What is due to completion regarding time lines
- List of work – critical issues, key milestones
- Critical linkages, delivery of this

Mr Oatridge confirmed he has discussed this with Ms Sarah Southall and Mr Marshall confirmed this can be modified.

RESOLVED: That the above is noted.

### **Communication and Engagement update**

WCCG.1818 Ms Roberts gave an overview of the report. She pointed out that due to the General Election on the 8 June 2017 communications outwards from the CCG and activity with the press has been limited and will continue until the period of purdah is closed. She stated that in order to relate to more of the general public there are new dates when the bus will be in Wolverhampton ~

14 June 2017 – Asda car park

15 June 2017 – Morrisons, Bilston

16 June 2017 – Sainsbury, Wednesfield then on to the Co-operative, Low Hill

Ms Roberts added that there will be a 5 minute video at the next Governing Body relating to The Wolverhampton Integrated Respiratory Lifestyle Project (TWIRL).

RESOLVED: That the above is noted.

### **Minutes of the Quality and Safety Committee**

WCCG.1819 RESOLVED: That the minutes are noted

### **Minutes of the Commissioning Committee**

WCCG.1820 RESOLVED: That the minutes are noted.

### **Minutes of the Finance and Performance Committee**

WCCG.1821 RESOLVED: That the minutes are noted..

### **Minutes of the Primary Care Joint Commissioning Committee**

WCCG.1822           RESOLVED: That the minutes are noted.

### **Minutes of the Primary Care Strategy Committee**

WCCG.1823           RESOLVED: That the minutes are noted.

### **Minutes of the Audit and Governance Committee**

WCCG.1824           RESOLVED: That the minutes are noted

### **Joint Negotiating and Consultation Committee**

WCCG.1825           RESOLVED: That the report is noted

### **Any Other Business**

WCCG.1826           Mr Watts reported that ideas will be shared from meetings taking place at Wolverhampton Council with the Governing Body after purdah has closed.

Ms Ros Jervis stated she will be leaving Wolverhampton Council in June 2017. Mr Oatridge wished her all the best in her new role.

Mr Oatridge thanked Ms Claire Skidmore for all her work at Wolverhampton CCG and wished her well in her new role.

RESOLVED: That the above is noted.

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

WCCG.1827           There were no questions.

### **Date of Next Meeting**

WCCG.1828           The Board noted that the next meeting was due to be held on **Tuesday 11 July 2017** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 2.50 pm

Chair.....

Date .....

DRAFT

**Wolverhampton Clinical Commissioning Group Governing Body**

**11 July 2017**

<b>Date of meeting</b>	<b>Minute Number</b>	<b>Action</b>	<b>By When</b>	<b>By Whom</b>	<b>Status</b>
14.2.17	WCCG.1706	Emergency Preparedness, Resilience and Response (EPRR) – a final report is submitted to the Governing Body.	September 2017	Mike Hastings/ Tally Kalea	
11.4.17	WCCG.1784	Better Care Fund Plan – the submitted plan and update on approval to be presented to the Governing Body	June/July 2017	Andrea Smith/ Steven Marshall	

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**WOLVERHAMPTON CCG**
**GOVERNING BODY**  
**11 JULY 2017**
**Agenda item 6**

<b>TITLE OF REPORT:</b>	Chief Officer Report
<b>AUTHOR(s) OF REPORT:</b>	Dr Helen Hibbs – Chief Officer
<b>MANAGEMENT LEAD:</b>	Dr Helen Hibbs – Chief Officer
<b>PURPOSE OF REPORT:</b>	To update the Governing Body on matters relating to the overall running of Wolverhampton Clinical Commissioning Group.
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This Report is intended for the public domain.
<b>KEY POINTS:</b>	<ul style="list-style-type: none"> <li>• Secondary Care Consultant – Mr Amarbaj Chandock has joined the CCG as our Secondary Care Consultant on the Governing Body.</li> <li>• Joint Commissioning - A joint Project Manager has been appointed to work across the four CCGs and will be working to ensure a project plan is in place with timescales and delivery objectives.</li> </ul>
<b>RECOMMENDATION:</b>	That the Governing Body note the content of the report.
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	
1. Improving the quality and safety of the services we commission	<p>This report provides assurance to the Governing Body of robust leadership across the CCG in delivery of its statutory duties.</p> <p>By its nature, this briefing includes matters relating to all domains contained within the BAF.</p>
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 Joint Commissioning**

- 2.1.1 The Black Country and West Birmingham Joint Commissioning Committee continues to meet monthly. A joint Project Manager has been appointed to work across the four CCGs and will be working to ensure a project plan is in place with timescales and delivery objectives. Wolverhampton CCG continues to be fully engaged in this work and is leading on Communications, Estates and IMT development as well as continuing our leadership of the Mental Health workstream which originated from the STP work.

### **2.2 Place Based Commissioning**

- 2.2.1 The CCG is working with partners including the Royal Wolverhampton NHS Trust, Black Country Partnership NHS Trust, General Practice and the Local Authority to determine what place based commissioning and provision will look like in the future in Wolverhampton

### **2.3 Primary Care Contracting**

- 2.3.1 On the first of April 2017 the CCG became responsible for the delivery of primary medical services (GP Practices) taking over this function from NHS England.
- 2.3.2 To support this function a Primary Care Contracting Manager was appointed into the Contracting Team and commenced in post on 3 May 2017. The primary function of this post is to manage and monitor the contracts the GPs hold to ensure they are working to their contract but they will also work closely with the Head of Primary Care in supporting the primary care strategy.
- 2.3.3 The main piece of work undertaken in these initial 2 months has been in procuring a temporary provider for a practice where the original provider had tendered their notice. This was successful in that a provider was awarded a contract for 21 months to run the practice from 1 July 2017.
- 2.3.4 The outgoing provider is now being supported through an exit planning process and the new provider through a mobilisation programme.

### **2.4 General Practice 5 Year Forward View**

- 2.4.1 The Primary Care Strategy Committee considered the extent of progress made regarding a range of projects that were now established. More than 50% of projects are now up and running comprising of:-



- A range of training programmes for primary care personnel i.e. Practice Manager, Aspiring Practice Manager, Time for Care, Nurse Mentorship, Apprenticeships, Care Navigation etc
- Recruitment and retention to a variety of roles include clinical pharmacists, social prescribers,
- Focus on new models of care and the developing general practice team
- Transformation work attached to the 10 High Impact Actions including working at scale and improving access

2.4.2 The programme of work will continue to be overseen by the committee.

## 2.5 **Secondary Care Consultant**

2.5.1 Welcome to Mr Amarbaj Chandock who is a gynaecological oncologist and has joined us as our Secondary Care Consultant on the Governing Body. Mr Chandock has experience of CCG work having served on the Governing Body of Bury CCG for several years and we look forward to working with him and using his considerable knowledge and expertise.

## 2.6 **NHS Confederation**

2.6.1 I attended the NHS confederation conference in Liverpool. Presentations were given by The Rt Hon Jeremy Hunt MP Secretary of State for Health and Mr Simon Stevens, Chief Executive of NHS England. Several presentations were given around accountable systems and the way they are developing in several Sustainability and Transformation Plan areas across the country.

## 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.

<b>Name</b>	<b>Dr Helen Hibbs</b>
<b>Job Title</b>	<b>Chief Officer</b>
<b>Date:</b>	<b>3 July 2017</b>



**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.**

	<b>Details/ Name</b>	<b>Date</b>
Clinical View	<b>N/A</b>	
Public/ Patient View	<b>N/A</b>	
Finance Implications discussed with Finance Team	<b>N/A</b>	
Quality Implications discussed with Quality and Risk Team	<b>N/A</b>	
Equality Implications discussed with CSU Equality and Inclusion Service	<b>N/A</b>	
Information Governance implications discussed with IG Support Officer	<b>N/A</b>	
Legal/ Policy implications discussed with Corporate Operations Manager	<b>N/A</b>	
Other Implications (Medicines management, estates, HR, IM&T etc.)	<b>N/A</b>	
Any relevant data requirements discussed with CSU Business Intelligence	<b>N/A</b>	
<b>Signed off by Report Owner (Must be completed)</b>	<b>Dr Helen Hibbs</b>	<b>03/07/17</b>



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**WOLVERHAMPTON CCG**
**Governing Body**  
**11 July 2017**
**Agenda item 7**

<b>TITLE OF REPORT:</b>	Update report: Equality and Inclusion requirements for NHS Workforce Race Equality Standard (WRES)  Update Equality Delivery System2 (EDS2)
<b>AUTHOR(s) OF REPORT:</b>	Juliet Herbert – Equality and Inclusion Business Partner
<b>MANAGEMENT LEAD:</b>	Manjeet Garcha
<b>PURPOSE OF REPORT:</b>	To provide the Governing Body with information and assurance that the CCG meets the requirements for NHS WRES 2017.  To provide the Governing Body with year one of the EDS2 action plan, to start the process of improving the EDS2 grading from 'Developing' to 'Achieving'.
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This Report is intended for the public domain
<b>KEY POINTS:</b>	<ul style="list-style-type: none"> <li>• Demonstrate how the CCG meets the NHS WRES requirements</li> <li>• To agree the year one EDS2 action plan</li> </ul>
<b>RECOMMENDATION:</b>	The Governing Body are asked to: <ul style="list-style-type: none"> <li>• Note the contents of the report and the sound progress being made</li> <li>• Approve appendix 1 and for the statement commitment to be published on the website</li> <li>• Agree EDS2 year one action plan</li> <li>• Agree the approach to update the Equality Strategy</li> </ul>
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	Equality, Inclusion and Human Rights (EIHR) are relevant to the 3 strategic aims of the CCG as their provision centres around servicers/patients. EIHR primary focus is centred around the safety and protection of people who maybe service users/patients that fall into protected groups according to the Equality Act (2010).

<p>1. Improving the quality and safety of the services we commission</p>	<p><u>Ensure on-going safety and performance in the system</u> 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</p>
<p>2. Reducing Health Inequalities in Wolverhampton</p>	<p><u>Improve and develop primary care in Wolverhampton</u> – 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</p> <p><u>Deliver new models of care that support care closer to home and improve management of Long Term Conditions</u> 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</p>
<p>3. System effectiveness delivered within our financial envelope</p>	<p><u>Proactively drive our contribution to the Black Country STP</u> 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.</p> <p><u>Greater integration of health and social care services across Wolverhampton</u> 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.’</p> <p><u>Continue to meet our Statutory Duties and responsibilities</u> 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</p> <p><u>Deliver improvements in the infrastructure for health and care across Wolverhampton</u> 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.</p>



## 1. NHS Workforce Race Equality Standard (WRES) requirements for CCG's

### Introduction

- 1.1. NHS England has released updated Technical Guidance (March 2017) for the implementation of WRES. This guidance sets out the over-arching purpose of the WRES and the responsibilities of both Commissioner and Provider organisations.
- 1.2 The main purpose of the WRES is:
  - to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators;
  - to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and;
  - to improve BME representation at the Board level of the organisation;
- 1.3 Since April 2015, the WRES has been included in the full length NHS Standard Contract only, which is mandated for use by NHS commissioners when commissioning non-primary health services. The Contract requires all providers (NHS and independent organisations) of NHS services (other than primary care) to address the issue of workforce race inequality by implementing and using the WRES.
- 1.4 Service Condition 13.6 of the NHS Standard Contract 2017/18 and 2018/19 state the following in relation to the WRES:
 

*'The Provider must implement the National Workforce Race Equality Standard and submit an annual report to the Co-ordinating Commissioner on its progress in implementing that standard.'*
- 1.5 Schedule 6A of the NHS Standard Contract requires that providers report annually on their compliance with the WRES.

### Requirements on CCG's and Associated Responsibilities

- 1.6 Clinical Commissioning Groups (CCGs) have two roles in relations to the WRES:
  - as commissioners of NHS services and;
  - as employers;
- 1.7 In addition to the NHS standard contract, the CCG Improvement and Assessment Framework also requires CCGs to give assurance to NHS England that their providers are implementing and using the WRES.
- 1.8 Implementing the WRES and working on its results and subsequent action plans should be a part of contract monitoring and negotiation between CCGs and their

respective providers in terms of meaningful dialogue to gain assurances of effective implementation and actions. However, the credibility of the CCGs relationship with its providers can only be meaningful if the CCG itself is taking serious action to improve its own performance against the WRES indicators.

- 1.9 The final standard states that ‘an annual report will be required to be submitted to the Co-ordinating Commissioner outlining progress against the Standard’. The Standard will have to be considered in relation to contract monitoring and compliance. The standard should also be applied to non – NHS providers including the voluntary and private sector organisations.
- 1.10 Further specific guidance for CCGs and CSUs, which provides clarity on the expectation on them to evidence sufficient ‘due regard’ is being developed. This will support the CCGs to ensure that its workforce and Board reflect the community that it serves.
- 1.11 Currently the expectation is that Commissioners assure themselves through contract monitoring that provider organisations are meeting the requirements as outlined in the table below. The expectation is that EDS and WRES reporting should be separate as the two requirements are complementary but distinct.

<b>Millstones</b>	<b>Activity</b>
1 August 2017 and annual there after	<p>Publication of 31st March 2017 workforce data and Autumn 2016 staff survey data against all 9 indicators. In addition actions required to make continuous progress (the WRES Action Plan) should be set out, including where appropriate, analyses of the impact of the 2016 Action Plan.</p> <p>The WRES data report and the Action Plan should be:</p> <ul style="list-style-type: none"> <li>• shared with the Board, staff and other local interests;</li> <li>• submitted centrally via Unify 2 (applies to NHS providers only, and with regard to the WRES data report only)</li> <li>• presented to the lead commissioner (for NHS providers)</li> <li>• published on organisations’ websites</li> </ul> <p>*CCGs should give consideration to the issue of publishing data that has small numbers of staff.</p>
April 2017 – March 2018 and annual there after	Work to address any data shortcomings and to understand and address the concerns raised in the organisation’s WRES baseline data should be undertaken.





- 1.12. By using the WRES, it is expected that, year on year, all NHS organisations will improve workforce race equality and that these improvements will be measured and demonstrated through the annual publication of data for each of the WRES indicators. The requirement to do this forms part of CCG assurance frameworks, the NHS standard contract and the CQC inspection regime. Progress made will be benchmarked and published, organisation by organisation. As the WRES gathers momentum, published performance data will generate publicity and discussion, inside and outside organisations.

**CSU EIHR Team Actions supporting CCG customers:**

- 1.13. The Equality, Inclusion and Human Rights (EIHR) team will work with the CCG workforce leads to support them to have effective 'due regard' to the WRES. This will be done through analysis of workforce data and staff survey results where relevant.
- 1.14. The EIHR team will be working with CCG Contracting and Quality leads to ensure that appropriate assurance mechanisms are in place to support the CCG to comply with the new WRES. Additional support will be available to quality assure provider submissions.

Appendix 1 confirms the CCGs statement of commitment, which once approved will be published on the website, and later accompanied by the action plans in due course.

**2. Update Equality Delivery System2 (EDS2)**

- 2.1. At the 14 March 2017 Governing Body meeting the EDS2 portfolio was agreed and signed off and subsequently published on the CCG website on the 28 March 2017, well within the legal deadline.
- 2.2. As part of the review of performance for people with characteristics protected by the Equality Act 2010, the Governing Body agreed that there needed to be a dedicated focus for moving the CCG from 'Developing' to 'Achieving'.
- 2.3. Appendix 2 confirms year one activity which requires named responsible officer to take things forward. Once approved named responsible officers can move actions forward.

**3. CLINICAL VIEW**

- 3.1. The clinical view has been taken into account for every commissioning decision, therefore already considered.

**4. PATIENT AND PUBLIC VIEW**

- 4.1. The patient and public view would have already been considered. A purpose of EDS2 is to evidence previous and current CCG activity.

## 5. KEY RISKS AND MITIGATIONS

- 5.1. Not publishing the WRES statement of commitment by the 1 August 2017 would mean that the CCG aren't compliant with the legal requirements of WRES.

## 6. IMPACT ASSESSMENT

### *Financial and Resource Implications*

- 6.1. None for this report.

### *Quality and Safety Implications*

- 6.2. The implications on Quality and Safety are intrinsic to the report.

### *Equality Implications*

- 6.3. Equality implications are intrinsic to the report.

### *Legal and Policy Implications*

- 6.4. WRES is part of the Public Sector Equality Duty which is a statutory duty of the Equality Act 2010. Any breaches of the duty could leave the CCG decision makers vulnerable to legal challenge.

- 6.5. There are also NHS England mandatory equality requirements that CCG's needs to ensure their providers are compliant. Any breaches here would compromise the equality compliance of the CCG.

### *Other Implications*

- 6.6. None (Do you have any Manjeet?)

**Name:** Juliet Herbert

**Job Title:** Equality & Inclusion Business Partner

**Date:** 11 July 2017

**ATTACHED:** Appendix 1 – WRES Statement of Commitment  
Appendix 2 – EDS2 Action Plan.

(Attached items:)

**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.**

	<b>Details/ Name</b>	<b>Date</b>
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	Steve Forsyth	?
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	
<b>Signed off by Report Owner (Must be completed)</b>	N/A	

## 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	<p>a. <u>Ensure on-going safety and performance in the system</u> 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</p>
2. Reducing health inequalities in Wolverhampton	<p>a. <u>Improve and develop primary care in Wolverhampton</u> – 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</p> <p>b. <u>Deliver new models of care that support care closer to home and improve management of Long Term Conditions</u> 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</p>
3. System effectiveness delivered within our financial envelope	<p>a. <u>Proactively drive our contribution to the Black Country STP</u> 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.</p> <p>b. <u>Greater integration of health and social care services across Wolverhampton</u> 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.’</p> <p>c. <u>Continue to meet our Statutory Duties and responsibilities</u> 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</p> <p>d. <u>Deliver improvements in the infrastructure for health and care across Wolverhampton</u> 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.</p>

## Appendix 1

### NHS Wolverhampton CCG commitment to the Workforce Race Equality Standard (WRES)

April 2015 NHS England mandated WRES for all NHS commissioners and their larger provider partner organisations where the combined contract value exceeds £200K per annum.

Since April 2015 NHS Wolverhampton CCG (WCCG) has remained committed to the requirements and principles of WRES. As an employer WCCG employs 100 members of staff, and due to the small number, a detailed breakdown of the staff profile by protected characteristic would reveal identifiable data, which is a breach of data protection legislation, which protects the privacy of employees.

As part of meeting our legal duties the CCG believes that equality is about creating a fairer society and diversity is about recognising and valuing difference in its broadest sense, and as part of our commitment to having due regard to the WRES, we believe that the CCG workforce is pivotal in implementing and delivering change both as an employer and commissioner.

All workforce policies have been developed, implemented and reviewed in line with equality legislation requirements and as a commissioner we believe that equality and diversity should include addressing health inequalities as well as being embedded into all commissioning activity. Here at WCCG equality and diversity are central to commissioning plans.

Also as commissioner we need to gain assurance that our large providers are committed to achieving the requirements of WRES. To achieve this we will carry out a comprehensive review of both templates and action plans submitted with a view to providing feedback where appropriate.

An action plan based on the findings from the WRES template for the WCCG will be published shortly.

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# EQUALITY DELIVERY SYSTEM 2 (EDS2)

- Introduction
- Executive Summary
  - Reminders
- CCG approach

## Action Plan 2017-2018



## Introduction

The **Equality Delivery System2 (EDS2) framework** was designed by the NHS to support NHS commissioners and providers to meet their duties under the Equality Act. The EDS has four goals, supported by 18 outcomes.

The Equality Act 2010 requires NHS Clinical Commissioning Groups (CCGs) to annually publish information which demonstrates progress the CCG is making in continuing to comply with the Act. The EDS2 framework identifies four over-arching goals to support NHS organisations to structure their action plans, these are:

- **Goal 1:** Better health outcomes for all
- **Goal 2:** Improved patient access and experience
- **Goal 3:** A representative and supported workforce
- **Goal 4:** Inclusive leadership.

EDS2 should be applied to people whose characteristics are protected by the Equality Act 2010. The nine characteristics are as follows:

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

Other disadvantaged groups include people who are:

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

These groups may have specific relevance to Wolverhampton demographics and should be included with the protected characteristic only when proportionate and relevant.



## Executive Summary

NHS organisations should make the EDS2 work for them, and adapt its processes and content to suit their local needs and circumstances.

Wolverhampton CCG took the following steps:

- senior management confirmed their commitment to the requirements of the EDS2 as part of a full discussion at their Governing body;
- identified key internal stakeholders to be involved;
- assembled their evidence using the internal stakeholders;
- the Equality & Inclusion Business Partner was used as the single point of contact for identified evidence and completed the EDS2 portfolio of evidence;
- the final portfolio of evidence was signed-off by the governing body;
- the Equality & Inclusion Business Partner organised the publication of the portfolio of evidence, to meet the 31 March 2017 deadline;

The EDS2 overall rating:

Undeveloped	Developing	Achieving	Excelling
Undeveloped if there is <b>no evidence</b> one way or another for any protected group of how people fare; <b>or</b> Undeveloped if evidence shows that the majority of people in only <b>2 or less protected groups</b> fare well	Developing if evidence shows the majority of people in <b>3 to 5 protected groups</b> fare well.	Achieving if evidence shows the majority of people in <b>6 to 8 protected groups</b> fare well.	Excelling if evidence shows the majority of people in <b>all 9 protected groups</b> fare well.

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WCCG's rating is 'Developing'. This means the assembled evidence showed in the majority of Wolverhampton people two - three protected groups fare well.

As part of the review of their performance for people with characteristics protected by the Equality Act 2010, senior management have agreed that there needs to be a dedicated focus for moving the CCG from 'Developing' to 'Achieving'. This would mean evidence shows the majority of people in four protected groups fare well.

## Reminders

### Human Rights

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

- **F**airness – at the heart of recruitment and selection processes (Goal 3)
- **R**espect – making sure complaints are dealt with respectfully (Goal 2)
- **E**quality – underpins commissioning (Goal 1)
- **D**ignity – core part of patient care and the treatment of staff (Goal 2 & 3)
- **A**utonomy – people should be involved as they wish to be in decisions about their care (Goal 2)  
*(Goal 4 would be a golden thread as part of all outcomes)*

These have been developed and embedded in the NHS constitution as principles that all NHS organisations should operate by.

### The Public Sector Equality Duty (PSED)

Using the EDS2 will help organisations respond to the PSED, and demonstrate their continued activities to meet the requirements to:

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

### Equality Delivery System for the NHS

The goals and outcomes of EDS2		
Goal	Number	Description of outcome
Better health outcomes	1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities
	1.2	Individual people's health needs are assessed and met in appropriate and effective ways
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed
	1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse
	1.5	Screening, vaccination and other health promotion services reach and benefit all local communities
Improved patient access and experience	2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care
	2.3	People report positive experiences of the NHS
	2.4	People's complaints about services are handled respectfully and efficiently
A representative and supported workforce	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
	3.3	Training and development opportunities are taken up and positively evaluated by all staff
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
	3.6	Staff report positive experiences of their membership of the workforce
Inclusive leadership	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
	4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

## Articles of the European Convention on Human Rights

The key human rights articles have been considered:

- Article 2 Right to life
  - Article 3 Freedom from torture and inhuman or degrading treatment
  - Article 4 Freedom from slavery and forced labour
  - Article 5 Right to liberty and security
  - Article 6 Right to a fair trial
  - Article 7 No punishment without law
  - Article 8 Respect for your private and family life, home and correspondence
  - Article 9 Freedom of thought, belief and religion
  - Article 10 Freedom of expression
  - Article 11 Freedom of assembly and association
  - Article 12 Right to marry and start a family
  - Article 14 Protection from discrimination in respect of these rights and freedoms
- 
- Protocol 1, Article 1 Right to peaceful enjoyment of your property
  - Protocol 1, Article 2 Right to education
  - Protocol 1, Article 3 Right to participate in free elections
- 
- Protocol 13, Article 1 Abolition of the death penalty

## Wolverhampton CCG Equality Objectives

1. To ensure that Leadership and Governance arrangements persist in offering high level assurance of equality.
2. Equality approaches are effectively included in key mechanisms of commissioning (such as business case development, procurement, contracting).
3. Equality Analysis becomes part of our organisational processes so that projects, policies, strategies, business cases, specifications and contracts have all been developed in consideration of equality, diversity and human rights issues.
4. To apply Goals 1 and 2 of the Equality Delivery System to an average of at least three patient pathways for each year of the strategy, and to demonstrate year on year improvements for Goals 3 and 4 (Staff and Leadership).
5. To regularly review and update the strategic action plan and equality objectives (on at least an annual basis) to ensure that it is providing appropriate targets for development and improvement.
6. To ensure all CCG staff receive basic training to ensure awareness of Equality Act 2010 responsibilities and the NHS Constitution, and that specific training on Equality Analysis and the Equality Delivery System is targeted to all staff who are involved in these processes.
7. To ensure that Equality and Diversity forms an ongoing part of our leadership and organisational development programmes.
8. To ensure that Equality and Diversity approaches are fully included in our engagement of people who use services and in our work with strategic partners and other stakeholders.
9. Improve accessibility of information and communication for people from statutorily 'protected groups' and other disadvantaged

## Vision


“Our vision is to provide the right care in the right place at the right time for all of our population. Our patients will experience seamless care, integrated around their needs and they will live longer with an improved quality of life”

## CCG Approach


An action plan has been developed which will be presented by the CCG Executive Lead for equality to the governing body, for sign-off and agreement to implement. The action plan will set out how the CCG will progress from an EDS2 regarding of ‘Developing’ to an EDS2 grading of ‘Achieving’. The action plan will be driven by the CCG in order to fully benefit from what learning will take place. The Equality & Inclusion Business Partner will provide expert advice, guidance and support (where appropriate and or relevant).

Wolverhampton CCG wants everybody to receive the highest quality and appropriate care for their needs, delivered from the right service, when the patient needs it.

**Action Plan 2017 – March 2018: EDS2 – Progression from ‘Developing’ to ‘Achieving’.**


1. Better health outcomes						Rag Rating
The NHS should achieve improvements in patient health, patient safety and public health for all, based on comprehensive evidence of needs and results						 Please fill the box with relevant colour
No.	Action	Deadline	Responsible Officer	Outcome/Impact	Updates/Comments	
1.	Review and update: <ul style="list-style-type: none"> <li>Commissioning process</li> <li>Procurement process</li> <li>Equality Analysis process</li> <li>Contract requirements and process</li> </ul>	Nov 2017		To demonstrate and evidence ‘due regard’ from a potential and risk perspective, clinical quality, ensuring EA’s are integral to other processes. This will provide better foundations for assurance both internally and externally.		
2.	Training: <ul style="list-style-type: none"> <li>Deliver Equality Analysis training</li> <li>Deliver Equality, diversity and inclusion training</li> </ul>	March 2018	Equality & Inclusion Business Partner	Staff will be equipped and understand expectations on them.		
3.	Intranet <ul style="list-style-type: none"> <li>Ensure the equality space on intranet is aligned with actions 1 &amp; 2,</li> </ul>	Dec 2017	Equality & Inclusion Business Partner	Commissioners will have a dedicated space that is informative and supportive.		
4.	Pilot reviewed approaches – see action 1	Nov 2017 to March 2018		Ensure every opportunity is provided to get things right and it starts the process of beginning to move from developing to achieving.		
5.	Embed EDS2 evidence in CCG business practice	March 2018		The CCG’s progress is continuous and an integral part of day-to-day activity.		

Performance Monitoring	Protected Characteristic (Please Tick)	Equality Objective (Please Tick)	Human Rights (Please Tick)	Are there any risks?	Comments	
	Age	✓	Objective 1	Article 2	✓	Article 11
	Disability	✓	Objective 2	Article 3	✓	Article 12
	Gender Re-assignment	✓	Objective 3	Article 4		Article 14
	Marriage & Civil Partnership	✓	Objective 4	Article 5	✓	
	Pregnancy & Maternity	✓	Objective 5	Article 6		Protocol 1, Article 1
	Race	✓	Objective 6	Article 7		Protocol 1, Article 2
	Religion or belief	✓	Objective 7	Article 8	✓	Protocol 1, Article 3
	Sex	✓	Objective 8	Article 9		Protocol 13, Article 1
	Sexual Orientation	✓	Objective 9	Article 10		

2. Improved patient access and experience						Rag Rating
The NHS should improve accessibility and information, delivering the right services that are targeted, useful and useable in order to improve patient experience						 Please fill the box with relevant colour
No.	Action	Deadline	Responsible Officer	Outcome/Impact	Updates/Comments	
1.	Ensure all relevant teams are collecting equality and diversity data	March 2018		To demonstrate and evidence 'due regard' of what protected groups fare well.		
2.	Agree protected characteristics to be monitored by providers, with an annual review	Sept 2017		The CCG can for its relevant providers, demonstrate and evidence 'due regard' of what protected groups fare well.		
3.	Review: Provider implementation of Accessible Information Standard	March 2018		The CCG are system leaders and a good source of support for providers.		
4.	Set up a specific Diversity Group linked to existing groups	March 2018	<b>Supported by the Equality And Inclusion Business Partner</b>	The CCG will have a dedicated forum to support equality analysis, communications and engagement activities.		


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Performance Monitoring	Protected Characteristic (Please Tick)	Equality Objective (Please Tick)	Human Rights (Please Tick)		Are there any risks?	Comments
	Age	✓	Objective 1	Article 2	✓ Article 11	
Disability	✓	Objective 2	Article 3	✓ Article 12		
Gender Re-assignment	✓	Objective 3	Article 4	Article 14	✓	
Marriage & Civil Partnership	✓	Objective 4	✓ Article 5	✓		
Pregnancy & Maternity	✓	Objective 5	✓ Article 6	Protocol 1, Article 1		
Race	✓	Objective 6	Article 7	Protocol 1, Article 2		
Religion or belief	✓	Objective 7	Article 8	Protocol 1, Article 3		
Sex	✓	Objective 8	Article 9	Protocol 13, Article 1		
Sexual Orientation	✓	Objective 9	Article 10	✓		

3. A representative and supported workforce						Rag Rating
The NHS should support the diversity of its workforce (whether paid or non-paid) to improve the quality of their working lives, enabling them to better respond to the needs of patients and local communities						 Please fill the box with relevant colour
No.	Action	Deadline	Responsible Officer	Outcome/Impact	Updates/Comments	
1.	The CCG can undertake detailed analysis of its' workforce	March 2018	Mike Hastings	The CCG can carry out detailed analysis of its' workforce profile by protected characteristic and demonstrate and evidence 'due regard' of what protected groups fare well.		
2.	The CCG is confident that their internal and external recruitment processes are equitable	March 2018	Mike Hastings	The CCG can carry out detailed analysis of its' workforce profile by protected characteristic and demonstrate and evidence 'due regard' of what protected groups fare well.		
3.	Assess how best the detailed analysis can inform staff development programmes that are linked to organisational development and the organisational development strategy.	March 2018	Mike Hastings	The CCG can carry out detailed analysis of its' workforce profile by protected characteristic to demonstrate and evidence what protected groups fare well.		
4.	Assess how best the staff survey can inform the quality of working lives.	March 2018	Mike Hastings	The CCG can carry out detailed analysis of its' workforce profile by protected characteristic and demonstrate and evidence 'due regard' of what protected groups fare well.		
5.	Review training/learning and development policy, practice and procedure	March 2018	Mike Hastings	Assess equality of opportunity and demonstrate and evidence 'due regard' of what protected groups fare well.		
6.	Staff Forum?		Mike Hastings	All staff including protected groups have a voice that is inclusive of equality issues.		

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Performance Monitoring	Protected Characteristic (Please Tick)	Equality Objective (Please Tick)	Human Rights (Please Tick)				Are there any risks?	Comments
	Age	✓	Objective 1	Article 2	✓	Article 11		
Disability	✓	Objective 2	Article 3	✓	Article 12			
Gender Re-assignment	✓	Objective 3	Article 4	✓	Article 14	✓		
Marriage & Civil Partnership	✓	Objective 4	✓	Article 5	✓			
Pregnancy & Maternity	✓	Objective 5	✓	Article 6		Protocol 1, Article 1		
Race	✓	Objective 6	✓	Article 7	✓	Protocol 1, Article 2		
Religion or belief	✓	Objective 7	✓	Article 8	✓	Protocol 1, Article 3		
Sex	✓	Objective 8		Article 9	✓	Protocol 13, Article 1		
Sexual Orientation	✓	Objective 9		Article 10	✓			

4 Inclusive leadership						Rag Rating
NHS organisations should ensure that equality is everyone's business with everyone taking an active role						 Please fill the box with relevant colour
No.	Action	Deadline	Responsible Officer	Outcome/Impact	Updates/Comments	
1.	Formalise Equality Champions?			The CCG has senior staff and leaders to promote equality and inclusive practice internal and externally to the CCG		
2.	Enhance available of equality considerations made through the governance processes			Raising the profile of CCG leaders and senior staff are delivering their commitment to inclusive practice  Demonstrate what CCG leaders and senior staff are doing to empower the system to be inclusive		
3.	Develop communication opportunities for CCG Leaders and Senior Staff to share outcomes of delivering their commitment to inclusive practice and empowering the system to be inclusive.			Evidence raising the profile of CCG leaders and senior staff are delivering their commitment to inclusive practice  Evidence demonstrate what CCG leaders and senior staff are doing to empower the system to be inclusive		

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Performance Monitoring	Protected Characteristic (Please Tick)	Equality Objective (Please Tick)	Human Rights (Please Tick)				Are there any risks?	Comments
	Age	Objective 1	Article 2	Article 11				
Disability	Objective 2	Article 3	Article 12					
Gender Re-assignment	Objective 3	Article 4	Article 14					
Marriage & Civil Partnership	Objective 4	Article 5						
Pregnancy & Maternity	Objective 5	Article 6	Protocol 1, Article 1					
Race	Objective 6	Article 7	Protocol 1, Article 2					
Religion or belief	Objective 7	Article 8	Protocol 1, Article 3					
Sex	Objective 8	Article 9	Protocol 13, Article 1					
Sexual Orientation	Objective 9	Article 10						

Key	
Red	Overdue
Amber	Started not complete
Green	Completed
Blue	Planned Work



**WOLVERHAMPTON CCG**
**GOVERNING BODY**  
**11 JULY 2017**
**Agenda item 8**

<b>TITLE OF REPORT:</b>	<b>Variation to the Constitution</b>
<b>AUTHOR(s) OF REPORT:</b>	Peter McKenzie, Corporate Operations Manager
<b>MANAGEMENT LEAD:</b>	Peter McKenzie, Corporate Operations Manager
<b>PURPOSE OF REPORT:</b>	To ask the Governing Body to authorise the submission of an application to vary the CCG's constitution to amend the GP representation on the Governing Body, to reflect the appointment of a Joint Chief Finance Officer with Walsall CCG, include the establishment of the Joint Committee with Dudley, Sandwell and West Birmingham and Walsall CCGs and to insert details of Committee roles in considering risks as part of revised risk management arrangements
<b>ACTION REQUIRED:</b>	<input checked="" type="checkbox"/> <b>Decision</b> <input type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This Report is intended for the public domain
<b>KEY POINTS:</b>	<ul style="list-style-type: none"> <li>• Following discussions with the GP membership, a new model of GP representation on the Governing Body has been agreed.</li> <li>• To allow the implementation of this model and to proceed with the election process, an application to NHS England to amend the constitution is required.</li> <li>• As part of the variation, a number of other minor changes will be made as outlined above.</li> </ul>
<b>RECOMMENDATION:</b>	To Authorise the Interim Chair and Accountable Officer to make an application to vary the CCG's Constitution in line with the changes described in the report.
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	[Outline how the report is relevant to the Strategic Aims and objectives in the Board Assurance Framework – See Notes for Further information]
2. Reducing Health	<u>Improve and develop primary care in Wolverhampton</u> The agreed model for GP representation includes linkages to

Inequalities in Wolverhampton	the New Models of Care Grouping to ensure the delivery of improved Primary Care remains at the heart of the Governing Body's work
3. System effectiveness delivered within our financial envelope	Continue to meet our <u>Statutory Duties and responsibilities</u> There is a statutory requirement for the CCG to have an up to date, published constitution. Making an application for a review will ensure that the CCG will have a constitution that reflects its planned operating approach.

## 1. BACKGROUND AND CURRENT SITUATION

- 1.1 The CCG's constitution is its primary Governance document, setting out how decisions are made, by whom and the roles of the Membership, the Governing Body, Committees and holders of specific roles. In order to progress proposed changes in the election process for GP members, the constitution will need to be changed.
- 1.2 NHS England are responsible for agreeing changes to CCG constitutions. They set out the procedure for making these variations in statutory guidance. This states that, when the CCG wishes to make a change they should submit an application detailing the proposed changes and an assessment of the impact of these changes.

## 2. GOVERNING BODY ELECTED GP POSITIONS

- 2.1 Following changes to the CCG's constitution which took effect in 2015, the Governing Body has eight positions for elected GP members. This is made up of five GPs elected across the city, from whom the roles of Clinical Chair and Clinical leads for Finance and Performance, Commissioning and Contracting and Quality and Safety have been drawn and three GPs elected to represent the three localities in the City.
- 2.2 As a result of a number of drivers, including the CCG's Primary Care Strategy, NHS England's GP Forward View and proactive efforts to improve patient care, GP practices in Wolverhampton are working much more closely together in defined clinical groupings which cut across the current localities. As a result of this, the GP membership and the Governing Body were concerned that the existing approach to electing GPs from the localities was no longer appropriate.
- 2.3 Discussions have taken place over a number of months which the leaders of the Clinical groups, culminating in a discussion at the CCG membership meeting in April 2017. At that meeting, it was agreed that a new model of representation for the elected GP representatives would be developed based on direct representation for the clinical groups.

- 2.4 At the members meeting, it was agreed that the detail of this model would be discussed and agreed by the clinical group leaders to be included an application for constitutional variation by the Governing Body. The discussions have now taken place and the Group leaders have agreed that there should be seven elected GP representatives on the Governing Body, elected as follows:-
- A Clinical Chair – Elected by all of the GPs across the City
  - Six GPs to represent the Clinical Groups, allocated according to patient list size as follows:-
    - 3 Unity (Medical Chambers)
    - 1 Primary Care Home 1
    - 1 Primary Care Home 2
    - 1 Vertical Integration
- 2.5 These roles will be filled by election, with all GPs working in the city eligible to stand for and vote for the role of Chair (subject to any conflicts of interest etc.) and GPs from each of the clinical groups able to stand for and vote for the representatives of their groups. The election process will be overseen by the Local Medical Council to ensure transparency.
- 2.6 The roles of Clinical Leads which involve chairing committees will be drawn from the GPs elected to represent the clinical groups. In recognition of the on-going issues with managing conflicts of interest it has been highlighted throughout the discussions with the membership and group leads that any conflicts arising from their membership of the group (such as procurements where their group is bidding) will need to be actively managed. The importance of the Governing Body's overall corporate role has also been highlighted.
- 2.7 In order to reflect these changes in the Constitution, paragraph 6.9.2 of the constitution and Paragraphs 2.2.2 and 2.2.4 of Appendix E Standing Orders will need be amended. The references in the constitution to Locality Boards have been removed. A copy of the revised versions of these documents is appended.

### 3. OTHER CHANGES

- 3.1 As part of the variation process, a number of other changes will be made to the constitution as follows:-
- 3.1.1 **Risk Management** – As part of the CCG's response to an Internal Audit review of Risk Management Arrangements in 2016/17, the Risk Management Strategy is being revised to increase the ownership of risk by Governing Body committees. Each Committee will have its own defined risk profile and will consider and review risks on a regular basis throughout the year. To reflect this, the following wording will be inserted into the terms of reference of the Commissioning Committee, Finance and

Performance Committee, Primary Care Commissioning Committee and Quality and Safety Committee

***The Committee will be responsible for ensuring that risks identified through the CCG's risk management arrangements and allocated to the committee due to its relevance to its responsibilities are effectively managed through regular consideration of the committee's risk profile. The committee will assure the Audit and Governance Committee and the Governing Body that these risks are being managed, escalating and de-escalating risks as it considers necessary.***

**3.1.2 Black Country Joint Commissioning Committee** – Following the agreement to establish the Joint Committee, it needs to be reflected in the Constitution of the CCGs under Paragraph 6.5 (Joint Arrangements with Other CCGs). As the Joint Committee does not yet have any functions formally delegated to it, a further amendment will be required to change the scheme of Reservation and Delegation once the proposals for the delegation of strategic commissioning functions have been agreed.

**3.1.3 Chief Finance Officer** – The appointment of Walsall CCG's Chief Finance Officer as part of a Joint arrangement needs to be reflected in Paragraph 7.8 (Joint Appointments with Other Organisations). As part of the arrangements to replace the previous Chief Finance and Operating Officer, the Group's Director of Operations will also become a member of the Governing Body.

#### **4. CLINICAL VIEW**

4.1 The proposed changes have been discussed and agreed at Membership meetings and with Clinical Group leaders.

#### **5. PATIENT AND PUBLIC VIEW**

5.1 Not Applicable.

#### **6. KEY RISKS AND MITIGATIONS**

6.1 There are risks associated with the CCG's overall leadership and clinical engagement should there continue to be vacancies for the GP positions on the Governing Body. The proposed structure aims to mitigate this risk by reflecting the make up of Primary Care in Wolverhampton, but does have inherent risks associated with the management of conflicts of interest for GPs who are members of groups providing services.

6.2 Such risks are however inherent to the CCG's make up as a membership based clinical commissioning group. Robust policies and procedures to support the management of conflict of interests will continue to be applied to ensure there is transparency in the CCG's business.

## 7. IMPACT ASSESSMENT

### *Financial and Resource Implications*

7.1 The proposed Governing Body structure is in line with budgeted running cost expenditure.

### *Quality and Safety Implications*

7.2 There are no specific Quality and Safety implications associated with this report.

### *Equality Implications*

7.3 There are no specific equality implications associated with this report.

### *Legal and Policy Implications*

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

### *Other Implications*

7.5 There are no other implications arising from this report.

**Name** Peter McKenzie  
**Job Title** Corporate Operations Manager  
**Date:** June 2017

### **ATTACHED:**

Revised Constitution and Standing Orders

### 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.**

	<b>Details/ Name</b>	<b>Date</b>
Clinical View	Discussed at Membership and Group Leaders Meetings	April - June
Public/ Patient View	Not Applicable	
Finance Implications discussed with Finance Team	Not Applicable	
Quality Implications discussed with Quality and Risk Team	Not Applicable	
Equality Implications discussed with CSU Equality and Inclusion Service	Not Applicable	
Information Governance implications discussed with IG Support Officer	Not Applicable	
Legal/ Policy implications discussed with Corporate Operations Manager	Report Author	30/06/17
Other Implications (Medicines management, estates, HR, IM&T etc.)	Not Applicable	
Any relevant data requirements discussed with CSU Business Intelligence	Not Applicable	
<b>Signed off by Report Owner (Must be completed)</b>	<b>Peter McKenzie</b>	<b>30/06/17</b>

**NHS WOLVERHAMPTON  
CLINICAL COMMISSIONING GROUP**

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**CONSTITUTION APPENDIX E  
STANDING ORDERS**

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Version: [6]

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# **1. STATUTORY FRAMEWORK AND STATUS**

## **1.1. Introduction**

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

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

- a) the arrangements for conducting the business of the group;
- b) the appointment of member practice representatives;
- c) the procedure to be followed at meetings of the group, the governing body and any committees or sub-committees of the group or the governing body;
- d) the process to delegate powers,
- e) the protocol for declaration of interests and standards of conduct.

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

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

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

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

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

### 2.1. Composition of membership

- 2.1.1. Part 3 and Appendix B of the group's constitution provide details of the membership of the group.
- 2.1.2. Part 6 of the group's constitution provides details of the governing structure used in the group's decision-making processes, whilst Part 7 of the constitution outlines certain key roles and responsibilities within the group and its governing body, including the role of practice representatives at paragraph 7.1.

### 2.2. Key Roles and Appointment Processes

- 2.2.1. Paragraph 6.9.2 of the group's constitution sets out the composition of the group's governing body whilst Part 7 of the group's constitution identifies certain key roles and responsibilities within the group and its governing body. These Standing Orders set out how the group appoints individuals to these key positions using best practice and with reference to the national guidance on roles, attributes and skills.
- 2.2.2. The chair of the governing body, see 6.9.2(a) and 7.4 of the constitution, is subject to the following:
- a) **Nominations** – any eligible individual may put themselves forward for election and this must be done in the format, to the named individual(s) and by the date/time specified in the rules for that election.
  - b) **Eligibility** – any GP working in any member practice(s) on the date specified by the rules for the election who can demonstrate that they fulfil the criteria set out in the Chair's role description, unless disqualified by virtue of regulations or (e) below, subject to paragraph 8.3.6 of the constitution.
  - c) **Appointment process** – election by secret ballot, overseen by the Local Medical Committee, of all eligible GPs, as defined at (b) above;
  - d) **Term of office** – three years
  - e) **Eligibility for reappointment** – no individual will serve more than two consecutive terms of office;
  - f) **Grounds for removal from office** – no longer being a member of the governing body or a failure to perform to the required standard;
  - g) **Notice period** – three months to be served in writing to the Accountable Officer.
  - h) **By-elections** – if the position of Chair becomes vacant, the Governing Body will, as soon as practical, hold a by-election to fill the vacancy. In the interim

period, the deputy chair of the Governing Body will usual act as chair. If the Deputy Chair is unable to act as Chair, the Governing Body will appoint one of their number who is not an employee of the group to act as interim chair.

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

2.2.4. The six other GP members of the governing body, (see 6.9.2(b) of the constitution), will be subject to the following criteria and process :

- a) **Nominations** – any eligible GP can put themselves forward for election to the governing body and this must be done in the format, to the named individual(s) and by the date/time specified in the rules for that election;
- b) **Eligibility** – any GP working in any member practice(s) on the date specified by the rules for the election, unless disqualified by virtue of regulations or (e) below, subject to paragraph 8.3.6 of the constitution;
- c) **Appointment process** – the six places will be proportionately allocated to groupings of practices operating in the city using their patient list size. The current (May 2017) allocation to groupings is as follows:-

• <b>Unity (Medical Chambers)</b>	3
• <b>Primary Care Home 1</b>	1
• <b>Primary Care Home 2</b>	1
• <b>Vertical Integration</b>	1

The places will be filled by elections by secret ballot, overseen by the Local Medical Committee of all eligible GPs, as defined at (b) above, from each of the groupings;

- d) **Term of office** – three years subject to 2.2.4 (g) (notice period) below ;
- e) **Eligibility for reappointment** – no individual will serve more than two consecutive terms of office;
- f) **Grounds for removal from office** – no longer being eligible as defined at (b) above, failure to perform to the required standard or any proven misconduct that would in the case of an employee of the group, result in their dismissal;
- g) **Notice period** – three months to be served in writing to the Chair;
- h) **By-elections** – if any of the six places fall vacant, the Governing Body will determine if there will be a by-election to fill the vacancy for the remainder of that term. The winner of any election will only be deemed to have served

one term of office for the purposes of (e) above if their time in office is over eighteen months.

- 2.2.5. The practice representatives, see 7.1 of the constitution, are subject to the following:
- a) **Nominations** – any eligible GP or other primary care health professional can put themselves forward for selection as the practice representative;
  - b) **Eligibility** – any GP or other primary care health professional working in the member practice;
  - c) **Appointment process** – selection by the practice using a voting procedure including all of its eligible GPs and primary care health professionals and which has been documented and lodged with the group’s Accountable Officer, who will then be notified in writing as to who each representative is;
  - d) **Term of office** – three years subject to f) (removal from office) and g) (notice period);
  - e) **Eligibility for reappointment** – no individual will serve more than three consecutive terms of office;
  - f) **Grounds for removal from office** – no longer being eligible as defined at (b) above or failure to perform to the required standard;
  - g) **Notice period** – one month to be served in writing to the Accountable Officer.
- 2.2.6. The lay members, see 6.9.2 (c) and (d) of the constitution, are subject to the following:
- a) **Nominations** – persons who meet the requirements of and are not disqualified by regulations, will be invited to apply for these positions;
  - b) **Eligibility** – further qualifying criteria for each of the positions will be clearly set out and only applicants who meet those criteria will be considered, subject to paragraph 8.3.6 of the constitution;
  - c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to each position;
  - d) **Term of office** – five years, with the first term starting on the effective date of the group’s constitution;
  - e) **Eligibility for reappointment** – no individual will serve more than two terms of office

- f) **Grounds for removal from office** – no longer being eligible as defined at (b) above, failure to perform to the required standard or any proven misconduct that would in the case of an employee of the group result in their dismissal;
- g) **Notice period** – one month to be served in writing to the chair.

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

- a) **Nominations** – membership of the governing body will rest with the individual appointed as the group's Executive Nurse and applications will be sought by advertising that position;
- b) **Eligibility** – a registered nurse who will not, once appointed, also be employed in general practice or by any organisation from which the group secures any significant volume of provision, is not otherwise disqualified by regulations and who meets the specific criteria identified for the position, subject to paragraph 8.3.6 of the constitution;
- c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to the position;
- d) Terms relating to tenure in post, including cessation provisions will be determined by the post-holder's contract of employment with the group.

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

- a) **Nominations** – applications will be sought by advertising the position;
- b) **Eligibility** – a doctor who is/has been a secondary care specialist with a high level of understanding of how care is delivered in a secondary care setting, who is not employed in a member practice or any organisation from which the group secures any significant volume of provision, is not otherwise disqualified by regulations and who meets the specific criteria identified for the position, subject to paragraph 8.3.6 of the constitution;
- c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to the position;
- d) **Term of office** – five years, with the first term starting on the effective date of the group's constitution;
- e) **Eligibility for reappointment** – no individual will serve more than two terms of office;

- f) **Grounds for removal from office** – no longer being eligible as defined at (b) above, failure to perform to the required standard or any proven misconduct that would in the case of an employee of the group result in their dismissal;
- g) **Notice period** – one month to be served in writing to the Chair.

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

- a) **Nominations** – membership of the governing body will rest with the individual appointed as the group’s Chief Officer and applications will be sought by advertising that position;
- b) **Eligibility** – the qualifying criteria for the position will be clearly set out and only applicants who meet those criteria and are not disqualified by regulations will be considered, subject to paragraph 8.3.6 of the constitution;
- c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to the position. The appointment will then be formally confirmed by the NHS Commissioning Board;
- d) Terms relating to tenure in post, including cessation provisions will be determined by the post-holder’s contract of employment with the group.

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

- a) **Nominations** – applications for post as employee of the group;
- b) **Eligibility** – holder of recognised accountancy qualification with current membership of the relevant professional body who meets the other specified criteria identified for the position and is not disqualified by regulations, subject to paragraph 8.3.6 of the constitution;
- c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to the position;
- d) Terms relating to tenure in post, including cessation provisions will be determined by the post-holder’s contract of employment with the group.

2.2.11. The Group’s Director of Strategy and Transformation, see 6.9.2(h) and Director of Operations, see 6.9.2(i) are subject to the following;

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

- b) **Eligibility** – the qualifying criteria for the position will be clearly set out and only applicants who meet those criteria and are not disqualified by regulations will be considered, subject to paragraph 8.3.6 of the constitution;
- c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to the position;
- d) Terms relating to tenure in post, including cessation provisions will be determined by the post-holder’s contract of employment with the group.

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

- a) **Nominations** – applications will be sought by advertising the position;
- b) **Eligibility** – anyone who is/has been a GP practice manager with a high level of understanding of that role, who meets the other specified criteria identified for the position and is not disqualified by regulations, subject to paragraph 8.3.6 of the constitution;
- c) **Appointment process** – eligible applicants will be shortlisted and selected by interview using further criteria designed to identify the candidate best suited to the position;
- d) **Term of office** – five years, with the first term starting on the effective date of the group’s constitution;
- e) **Eligibility for reappointment** – no individual will serve more than two consecutive terms of office ;
- f) **Grounds for removal from office** – no longer being eligible as defined at (b) above, failure to perform to the required standard or any proven misconduct that would in the case of an employee of the group result in their dismissal;
- g) **Notice period** – one month’s to be served in writing to the chair.

### 3. MEETINGS OF THE CLINICAL COMMISSIONING GROUP

#### 3.1. Calling meetings

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

3.1.2. An extraordinary meeting of the group will be held if deemed necessary by the governing body or if requested in writing to the chair of the governing body by at

least ten practice representatives. At least one week's notice will be given to all members via an e-mail to their practice representative. Unless otherwise determined by the governing body or the chair thereof, because of the nature of the business of the meeting, the details of the date, time and venue of such meetings will be publicised on the group's website [www.wolverhamptonccg.nhs.uk](http://www.wolverhamptonccg.nhs.uk).

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

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

### **3.2. Agenda, supporting papers and business to be transacted**

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

3.2.2. Agendas and certain papers for meetings of the group and its governing body will be published on the group's website [www.wolverhamptonccg.nhs.uk](http://www.wolverhamptonccg.nhs.uk).

### **3.3. Petitions**

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

### **3.4. Chair of a meeting**

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

3.4.2. If the chair is absent temporarily on the grounds of a declared conflict of interest the deputy chair, if present, will preside for the relevant business of the meeting. If both the chair and deputy chair are absent or disqualified from participating, a



member of the forum who is able to participate will be chosen by the members present, or by a majority of them, and will preside.

### **3.5. Chair's ruling**

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

### **3.6. Quorum**

- 3.6.1. Meetings of the group will be quorate if more than 50% of the practices in the group are represented by their practice representative or any substitute notified in writing to the Accountable Officer at least 24 hours before the meeting was scheduled to start. If enough members are disqualified from taking part in a vote due to a declared interest that the meeting ceases to be quorate for that item of business, no such vote will be taken and the item and/or the remainder of the meeting (if it cannot be quorate thereafter) shall be adjourned and the business remaining on the agenda dealt with on a date to be agreed.
- 3.6.2. Meetings of the governing body will be quorate if more than 50% of the members as defined by paragraph 6.9.2 of the constitution, including at least half of the elected members, are present or represented by an individual as notified to the chair more than 24 hours before the meeting was scheduled to start. If the reason for the meeting not being quorate is that all or some of the elected members and the practice manager are disqualified from taking part in a vote due to a declared interest, in line with the group's arrangements for managing conflicts of interest, the meeting will be quorate provided that more than 50% of the other members of the Governing Body are present. . The chair of the meeting for that item of business will ensure that the requirements of the constitution at 8.4.9 and 8.4.10 have been met.
- 3.6.3. For all other of the group's committees and sub-committees, including the governing body's committees and sub-committees, the details of the quorum for these meetings and status of representatives are set out in the appropriate terms of reference and are governed by the constitution at 8.4.8 to 8.4.10 if declared interests reduce the membership for any item of business.

### **3.7. Decision making**

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

- a) **Eligibility** – practice representatives, or any substitute notified in writing to the Accountable Officer at least 24 hours before the meeting was scheduled to start, will be able to cast one vote on behalf of their practice.
- b) **Majority necessary to confirm a decision** - a simple majority of the members present and voting at the meeting;
- c) **Casting vote** - the chair of the meeting will have a casting vote in the unlikely event of no overall majority being established.

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

- a) **Eligibility** – members of the governing body as defined by paragraph 6.9.2 of the constitution will be able to cast one vote but others in attendance at the meeting will not. Any member who cannot attend the meeting and wishes their vote to be cast by a representative must have notified the Chair of the identity of that individual more than 24 hours before the meeting was scheduled to start;
- b) **Majority necessary to confirm a decision** – a simple majority
- c) **Casting vote** - the chair of the meeting will have a casting vote in the event of no overall majority being established.

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

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

### 3.8. **Emergency powers and urgent decisions**

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

3.8.2. Those powers that the group has delegated to the governing body may in an emergency or the need for an urgent decision be exercised by the Chair of the governing body and the Accountable Officer after consultation with at least two

other elected members of the governing body and the Chief Finance Officer if the group will, or is likely to, incur any excessive or unnecessary expenditure as a result of them not utilising the emergency powers, suffer exposure to a risk outside the group's stated risk appetite (including but not limited to prospective reputational damage) or other matter which, in the opinion of the Chair, requires an urgent decision to be taken prior to the next meeting of the governing body. The exercise of such powers will be reported to all members of the governing body as defined by paragraph 6.9.2 of the constitution and subsequently ratified (or not as the case may be) and recorded at the next meeting of the governing body. An urgent decision is one that needs to be taken before the next meeting of the governing body in order to ensure that the group meets its statutory, regulatory, governance and contractual obligations.

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

### **3.9. Suspension of Standing Orders**

- 3.9.1. Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or NHS England, any part of these Standing Orders may be suspended at any meeting, provided a simple majority plus one of the voting members of that meeting are in agreement.
- 3.9.2. A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.
- 3.9.3. A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the governing body's Audit and Governance Committee for review of the reasonableness of the decision to suspend Standing Orders.

### **3.10. Records of Attendance**

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

### **3.11. Minutes**

- 3.11.1. It will be the responsibility of the person chairing any meeting to ensure that an individual has been identified to take and draft the minutes of that meeting. The chair of that meeting will confirm the accuracy of those minutes before they are presented to the next meeting of that forum for formal approval and be signed off by the person chairing that subsequent meeting.
- 3.11.2. Minutes of meetings of the group and its governing body will be among the papers published on the group's website [www.wolverhamptonccg.nhs.uk](http://www.wolverhamptonccg.nhs.uk).

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

- 3.12.1. Employees of and providers of relevant services to the group and other representatives of any organisations with which it jointly commissions or from whom it commissions healthcare services will be invited to attend meetings of the governing body whenever the transaction of its business will be made more efficient and effective by their presence.
- 3.12.2. In addition, representatives of the following will be invited to attend and contribute from their perspective, to all meetings of the governing body as observers, declaring any interests as appropriate:
- the Local Medical Committee, as statutory representatives of the GP profession;
  - Wolverhampton City Council, as key commissioning partners and host of the local Public Health function;
  - Wolverhampton Health and Wellbeing Board, through which the group and the Council will develop joint strategic needs assessments and joint strategies;
  - local HealthWatch to represent patients/carers.
- 3.12.3. The public and representatives of the press may attend all meetings of the group and its governing body unless it is necessary to ask them and those invited to attend as observers, to withdraw under: (a) Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960 because of the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest; (b) Section 1(8) of that Act in the interests of public order.
- 3.12.4. Members and employees of the group who remain at a meeting whilst confidential business is discussed will treat the relevant papers, discussion and minutes as absolutely confidential and not to be disclosed outside of the group without express written permission to do so from the Chair or Deputy Chair of the governing body, the Accountable Officer or the Chair of the Audit and Governance Committee.
- 3.12.5. No member of the public or representative of the press will record or transmit a meeting of the group or its governing body without express permission from the chair of the meeting.

## **4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES**

### **4.1. Appointment of committees and sub-committees**

- 4.1.1. The group may appoint committees and sub-committees of the group, subject to any regulations made by the Secretary of State, and make provision for the appointment of committees and sub-committees of its governing body. Where such committees and sub-committees of the group or the governing body are appointed they are included in Chapter 6 of the group's constitution.
- 4.1.2. Other than where there are statutory requirements, such as in relation to the governing body's Audit and Governance and Remuneration committees, the

group shall determine the membership and terms of reference of committees and sub-committees and shall, if it requires, receive and consider reports of such committees at the next appropriate meeting of the group.

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

#### **4.2. Terms of Reference**

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

#### **4.3. Delegation of Powers by Committees to Sub-committees**

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

#### **4.4. Approval of Appointments to Committees and Sub-Committees**

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

### **5. DUTY TO REPORT NON-COMPLIANCE WITH STANDING ORDERS**

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

### **6. USE OF SEAL AND AUTHORISATION OF DOCUMENTS**

#### **6.1. Clinical Commissioning Group's seal**

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

- a) the Accountable Officer;

b) the Chair of the governing body;

c) the Chief Finance Officer;

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

## **6.2. Execution of a document by signature**

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

a) the Accountable Officer

b) the Chair of the governing body

c) the Chief Finance Officer

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

### **7.1. Policy statements: general principles**

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

**NHS WOLVERHAMPTON  
CLINICAL COMMISSIONING GROUP**

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**CONSTITUTION**

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Version: [8]

NHS England Effective Date: 1 April 2017

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## FOREWORD

NHS Wolverhampton Clinical Commissioning Group ('WCCG') aims to commission the highest quality, evidence-based care on behalf of its patients by investing in skills available locally and otherwise to design new and improved care pathways.

The clinical commissioning group will address health inequalities by being responsive to both patients and constituent practices. The engagement and support of its member practices will promote effective dialogue with providers aimed at bringing about the delivery of improved, cost effective health care.

WCCG will maintain a focus on health needs in Wolverhampton and commission cost effective services within the resources available.

The clinical commissioning group will adopt a culture in which individual practices engage in designing pathways and incorporate the needs of their practice population. The sum of these locally based approaches will help us to deliver our strategic commissioning objectives.

Practices will be supported through structured education and a quality improvement programme. This will help us to achieve common strategic objectives and standardise delivery of care for all of our patients.

The clinical commissioning group will share appropriate information with our constituent practices so that we can develop a better understanding of the needs in the locality for provision of different care patterns and the requirements of our constituent practices.

Appropriate governance mechanisms and information management tools will also be continuously developed. This will allow WCCG to share selective and essential data reflecting the achievements and shortcomings of the group, which can be shared with NHS England, the local authority public health function, Health and Wellbeing Board and – last but not least - patient groups.

The clinical commissioning group will maintain clear definitions and profiles for the roles and responsibilities of all governing body members and office holders. The corporate governance mechanisms will ensure that the Chair, Accountable Officer and all other Governing Body members have a clear brief. The objectives of all WCCG officers and Clinical Leads will be well defined through the Terms of Reference of our Committees and other documents and policies.

The clinical commissioning group works with third parties including the local authority and other statutory bodies in developing and implementing appropriate agreements in order to improve and develop local services. The group also works with NHS England to ensure that the services commissioned by it are an efficient and cost-effective part of the overall range of services available to the people of Wolverhampton.

Our focus will primarily be on maintaining and improving services for patients.

# 1. INTRODUCTION AND COMMENCEMENT

## 1.1. Name

- 1.1.1. The name of this clinical commissioning group is NHS Wolverhampton Clinical Commissioning Group.

## 1.2. Statutory Framework

- 1.2.1. Clinical commissioning groups are established under the Health and Social Care Act 2012 (“the 2012 Act”).<sup>1</sup> They are statutory bodies which have the function of commissioning services for the purposes of the health service in England and are treated as NHS bodies for the purposes of the National Health Service Act 2006 (“the 2006 Act”).<sup>2</sup> The duties of clinical commissioning groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act, and the regulations made under that provision.<sup>3</sup>
- 1.2.2. NHS England is responsible for determining applications from prospective groups to be established as clinical commissioning groups<sup>4</sup> and undertakes an annual assessment of each established group.<sup>5</sup> It has powers to intervene in a clinical commissioning group where it is satisfied that a group is failing, has failed to discharge any of its functions or there is a significant risk that it will fail to do so.<sup>6</sup>
- 1.2.3. Clinical commissioning groups are clinically-led membership organisations made up of general practices. The members of the clinical commissioning group are responsible for determining the governance arrangements for their organisations, which they are required to set out in a constitution.<sup>7</sup>

## 1.3. Status of this Constitution

- 1.3.1. This constitution has been approved by the members of NHS Wolverhampton Clinical Commissioning Group and has effect from 1 April 2015<sup>8</sup> The constitution is published on the group’s website at [www.wolverhamptonccg.nhs.uk](http://www.wolverhamptonccg.nhs.uk).
- 1.3.2. Copies of the constitution are available for inspection at the WCCG headquarters: Wolverhampton Science Park, Glaisher Drive, Wolverhampton WV10 9RU. Alternatively, on request, a copy will be posted or sent by email to any enquirer who may wish to receive this.

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<sup>1</sup> See section 1I of the 2006 Act, inserted by section 10 of the 2012 Act

<sup>2</sup> See section 275 of the 2006 Act, as amended by paragraph 140(2)(c) of Schedule 4 of the 2012 Act

<sup>3</sup> Duties of clinical commissioning groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act

<sup>4</sup> See section 14C of the 2006 Act, inserted by section 25 of the 2012 Act

<sup>5</sup> See section 14Z16 of the 2006 Act, inserted by section 26 of the 2012 Act

<sup>6</sup> See sections 14Z21 and 14Z22 of the 2006 Act, inserted by section 26 of the 2012 Act

<sup>7</sup> See in particular sections 14L, 14M, 14N and 14O of the 2006 Act, inserted by section 25 of the 2012 Act and Part 1 of Schedule 1A to the 2006 Act, inserted by Schedule 2 to the 2012 Act and any regulations issued

<sup>8</sup> See section 14D of the 2006 Act, inserted by section 25 of the 2012 Act

## **1.4. Amendment and Variation of this Constitution**

1.4.1. This constitution can only be varied in two circumstances.<sup>9</sup>

- a) where the group applies to NHS England and that variation is granted;
- b) where in the circumstances set out in legislation, NHS England varies the group's constitution other than on application by the group.

## **2. AREA COVERED**

2.1. The geographical area covered by NHS Wolverhampton Clinical Commissioning Group is the City of Wolverhampton.

## **3. MEMBERSHIP**

### **3.1. Membership of the Clinical Commissioning Group**

3.1.1. The practices listed in Appendix B comprise the members of NHS Wolverhampton Clinical Commissioning Group.

### **3.2. Eligibility**

3.2.1. Providers of primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract will be eligible to apply for membership of this group<sup>10</sup>.

## **4. MISSION, VISION, VALUES AND AIMS**

### **4.1. Mission**

4.1.1. The mission of NHS Wolverhampton Clinical Commissioning Group is:

We will be an expert clinical commissioning organisation, working collaboratively with our patients, practices and partners across health and social care to ensure evidence-based, equitable, high quality and sustainable services for all of our population.

4.1.2. The group will promote good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

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<sup>9</sup> See sections 14E and 14F of the 2006 Act, inserted by section 25 of the 2012 Act and any regulations issued

<sup>10</sup> See section 14A(4) of the 2006 Act, inserted by section 25 of the 2012 Act and any regulations issued

## **4.2. Vision**

- 4.2.1. Our vision is for the right care in the right place at the right time for all of our population. Our aim is to ensure that patients will experience seamless care, integrated around their needs, and they will live longer with improved quality of life.

## **4.3. Values**

- 4.3.1. Good corporate governance arrangements are critical to achieving the group's objectives.

- 4.3.2. The values that lie at the heart of the group's work are:

- a) to be a dynamic, responsive and innovative organisation;
- b) to drive the commissioning agenda in Wolverhampton ;
- c) to be a trusted and valued partner contributing positively to the health and social care economy;
- d) to have a proactive, inclusive, equitable and professional approach that will secure best value for money and high quality in all that we do;
- e) to be open and responsive to the local population, patients and clinicians;
- f) to have ways of working that encourage people to want to work for and with us.

## **4.4. Aims**

- 4.4.1. The group's aims are to:

- a) improve and simplify arrangements for urgent care;
- b) address variations in the quality of planned care;
- c) improve the care of those with chronic conditions;
- d) reduce health inequalities across Wolverhampton ;
- e) commission the highest quality of services within available resources.

## **4.5. Principles of Good Governance**

- 4.5.1. In accordance with section 14L(2)(b) of the 2006 Act,<sup>11</sup> the group will at all times observe "such generally accepted principles of good governance" in the way it conducts its business. These include:

- a) the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;
- b) *The Good Governance Standard for Public Services*;<sup>12</sup>

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<sup>11</sup> Inserted by section 25 of the 2012 Act

<sup>12</sup> *The Good Governance Standard for Public Services*, The Independent Commission on Good Governance in Public Services, Office of Public Management (OPM) and The Chartered Institute of Public Finance & Accountability (CIPFA), 2004

- c) the standards of behaviour published by the *Committee on Standards in Public Life (1995)* known as the 'Nolan Principles'<sup>13</sup>
- d) the seven key principles of the *NHS Constitution*;<sup>14</sup>
- e) the Equality Act 2010.<sup>15</sup>

## 4.6. Accountability

4.6.1. The group will demonstrate its accountability to its members, local people, stakeholders and NHS England in a number of ways, including by:

- a) publishing its constitution;
- b) appointing independent lay members and non-GP clinicians to its governing body;
- c) holding meetings of its governing body in public (except where the group considers that it would not be in the public interest in relation to all or part of a meeting);
- d) publishing annually a commissioning plan;
- e) complying with local authority health overview and scrutiny requirements;
- f) meeting annually in public to publish and present its annual report (which must be published);
- g) producing annual accounts in respect of each financial year which must be externally audited;
- h) having a published and clear complaints process;
- i) complying with the Freedom of Information Act 2000;
- j) providing information to NHS England as required.

4.6.2. In addition to these statutory requirements, the group will demonstrate its accountability by:

- a) making its principal commissioning policies available on its internet site;
- b) holding public engagement events.

4.6.3. The governing body of the group will throughout each year have an ongoing role in reviewing the group's governance arrangements to ensure that the group continues to reflect the principles of good governance.

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<sup>13</sup> See Appendix C

<sup>14</sup> See Appendix D

<sup>15</sup> See <http://www.legislation.gov.uk/ukpga/2010/15/contents>

## 5. FUNCTIONS AND GENERAL DUTIES

### 5.1. Functions

5.1.1. The functions that the group is responsible for exercising are largely set out in the 2006 Act, as amended by the 2012 Act. An outline of these appears in the Department of Health's Functions of clinical commissioning groups: a working document. They relate to:

- a) commissioning certain health services (where NHS England is not under a duty to do so) that meet the reasonable needs of:
  - i) all people registered with our member practices, and
  - ii) people who are usually resident within our area and are not registered with a member of any clinical commissioning group;
- b) commissioning emergency care for anyone present in our area;
- c) meeting the costs of prescriptions written by our member practices;
- d) paying our employees' remuneration, fees and allowances in accordance with the determinations made by the governing body and determining any other terms and conditions of service of the group's employees;
- e) determining the remuneration and travelling or other allowances of members of our governing body.

5.1.2. In discharging its functions the group will:

- a) act<sup>16</sup>, when exercising its functions to commission health services, consistently with the discharge by the Secretary of State and NHS England of their duty to *promote a comprehensive health service*<sup>17</sup> and with the objectives and requirements placed on NHS England through *the mandate*<sup>18</sup> published by the Secretary of State before the start of each financial year, by:
  - i) delegating responsibility for delivering this duty to the governing body;
  - ii) establishing a Commissioning Committee to support the governing body in meeting that responsibility;
  - iii) agreeing a Commissioning Policy consistent with this duty;
  - iv) requiring our performance in delivery of this duty to be monitored by the Audit and Governance Committee.

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<sup>16</sup> See section 3(1F) of the 2006 Act, inserted by section 13 of the 2012 Act

<sup>17</sup> See section 1 of the 2006 Act, as amended by section 1 of the 2012 Act

<sup>18</sup> See section 13A of the 2006 Act, inserted by section 23 of the 2012 Act

- b) meet the *public sector equality duty*<sup>19</sup> by:
  - i) delegating responsibility for delivering this duty to the Accountable Officer, who will discharge it using the Equality Delivery System toolkit;
  - ii) agreeing an Equality and Diversity policy that, inter alia, requires all policies to be written with due regard for the group's responsibilities under the Equality Act 2010;
  - iii) publishing at least annually sufficient information to demonstrate our compliance with this general duty across all our functions;
  - iv) preparing, publishing and revising at least every four years our specific and measurable equality objectives;
  - v) requiring our performance in delivery of this duty to be monitored by the Quality and Safety Committee.
  
- c) work in partnership with our local authority to develop *joint strategic needs assessments*<sup>20</sup> and *joint health and wellbeing strategies*<sup>21</sup> by:
  - i) ensuring that we are an effective member of the Wolverhampton Health and Wellbeing Board, on which we will be represented by an elected member of the governing body;
  - ii) requiring our representatives on that Board to report to the governing body, as well as the Finance and Performance and Quality and Safety Committees as appropriate, with regard to development of the joint assessments and strategies and delivery of the latter;
  - iii) delivering our duty under 5.2.13 below to integrate health services with health-related and social care services when appropriate to do so.

**5.2. General Duties** - in discharging its functions the group will:

5.2.1. Make arrangements to *secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements*<sup>22</sup> by:

- a) delegating responsibility for delivering this duty to the Accountable Officer;
- b) working in partnership with patients and the local community to secure the best care for them;
- c) publishing information about health services on our website and adopting engagement activities that meet the specific needs of our different patient groups and communities;
- d) ensuring that, as part of any of our processes for potential or actual changes to commissioning arrangements, there is appropriate consultation with or provision of information to the individuals for whom those changes could or would have an impact on the manner in which services are delivered to them or the range of services available to them;
- e) encouraging and acting on feedback;

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<sup>19</sup> See section 149 of the Equality Act 2010, as amended by paragraphs 184 and 186 of Schedule 5 of the 2012 Act

<sup>20</sup> See section 116 of the Local Government and Public Involvement in Health Act 2007, as amended by section 192 of the 2012 Act

<sup>21</sup> See section 116A of the Local Government and Public Involvement in Health Act 2007, as inserted by section 191 of the 2012 Act

<sup>22</sup> See section 14Z2 of the 2006 Act, inserted by section 26 of the 2012 Act



- f) thus delivering the *Statement of Principles* below;
- g) requiring our compliance with this *Statement* to be monitored by the Quality and Safety Committee.

### **Statement of Principles**

We will:

- commission high quality, patient-centred care;
- improve patient care by focussing on quality, including outcomes;
- adhere to evidenced based decision making;
- treat patients, carers and their representatives with respect;
- be open about what is possible, what cannot be changed and why;
- involve local people in decision making;
- respond to concerns and views and demonstrate how we have responded and what impact this has had;
- include those who are marginalised and considered 'hard to reach', by understanding our communities and stakeholders and valuing partnership working;
- undertake decision making in a fair way so that no group is significantly disadvantaged by the decisions we take;
- demonstrate a commitment to learning and development, exploring different ways of working and evaluating and implementing our learning for continual improvement.

5.2.2. *Promote awareness of, and act with a view to securing that health services are provided in a way that promotes awareness of, and have regard to the NHS Constitution*<sup>23</sup> by:

- a) delegating responsibility for delivering this duty to the Accountable Officer, who will ensure that our arrangements for public engagement promote awareness of the *NHS Constitution*;
- b) encouraging and supporting our constituent practices to provide health services in a manner that is consistent with this duty;
- c) including within our Commissioning Policy a requirement to ensure that the health services we commission are provided in a manner that is consistent with this duty;
- d) requiring our performance in delivery of this duty to be monitored by the Quality and Safety Committee.

5.2.3. *Act effectively, efficiently and economically*<sup>24</sup> by:

- a) delegating responsibility for delivering this duty to the governing body;
- b) establishing a Finance and Performance Committee to support the governing body in meeting that responsibility;

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<sup>23</sup> See section 14P of the 2006 Act, inserted by section 26 of the 2012 Act and section 2 of the Health Act 2009 (as amended by 2012 Act)

<sup>24</sup> See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act

- c) using our Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies as the policy framework through which this duty will be delivered;
- d) requiring our performance in delivery of this duty to be monitored by the Audit and Governance Committee.

5.2.4. Act with a view to *securing continuous improvement to the quality of services*<sup>25</sup> by:

- a) delegating responsibility for delivering this duty to the Executive Nurse, who will ensure that we are a learning organisation;
- b) establishing a Commissioning Committee to support the Executive Nurse in meeting that responsibility;
- c) including within our Commissioning and Contract Management Policies the requirement to ensure that services are commissioned and their delivery monitored in a manner that strives for continuous improvement in effectiveness, safety and quality;
- d) requiring our performance in delivery of this duty to be monitored by the Quality and Safety Committee.

5.2.5. Assist and support NHS England in relation to its duty to *improve the quality of primary medical services*<sup>26</sup> by:

- a) delegating responsibility for delivering this duty to the Accountable Officer;
- b) agreeing with each of the constituent practices an Improving Quality of Primary Medical Services Policy that ensures the delivery of this duty in a manner so as to achieve a caring and responsible culture and environment;
- c) requiring our performance in delivery of this duty to be monitored by the Quality and Safety Committee.

5.2.6. Have regard to the need to *reduce inequalities*<sup>27</sup> by:

- a) delegating responsibility for delivering this duty to the Accountable Officer, who will discharge it in a manner consistent with our public sector equality duty at 5.1.2(b) above;
- b) including within our Commissioning Policy the requirement to deliver our aim to reduce inequalities in patients' ability to access services and/or in the outcomes being delivered by the services they do use;
- c) developing commissioning strategies and plans consistent with that policy requirement;
- d) requiring our performance in delivery of this duty to be monitored by the Finance and Performance Committee.

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<sup>25</sup> See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act

<sup>26</sup> See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act

<sup>27</sup> See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act

- 5.2.7. *Promote the involvement of patients, their carers' and representatives in decisions about their healthcare*<sup>28</sup> by:
- a) delegating responsibility for delivering this duty and those stated at b) to d) below to the Executive Nurse, who will be required to ensure its application with regard to prevention, diagnosis and treatment;
  - b) encouraging and supporting our constituent practices to provide health services in a manner that is consistent with this duty;
  - c) including within our Commissioning Policy a requirement to ensure that the health services we commission are provided in a manner that is consistent with this duty;
  - d) requiring our performance in delivery of this duty to be monitored by the Quality and Safety Committee.
- 5.2.8. *Act with a view to enabling patients to make choices*<sup>29</sup> by:
- a) delegating responsibility for delivering this duty and those at b) to e) below to the Executive Nurse ;
  - b) encouraging and supporting our constituent practices to provide health services and refer patients to secondary health services in a manner that is consistent with this duty;
  - c) including within our Commissioning Policy a requirement to ensure that we commission services in a manner that is consistent with this duty;
  - d) including within our Commissioning Policy a requirement to ensure that the health services we commission are provided in a manner that is consistent with this duty;
  - e) requiring our performance in delivery of this duty to be monitored by the Quality and Safety Committee.
- 5.2.9. *Obtain appropriate advice*<sup>30</sup> from persons who, taken together, have a broad range of professional expertise in healthcare and public health by:
- a) delegating responsibility for delivering this duty to the Accountable Officer, who will be required to ensure its application with regard to needs assessments, overall strategies and plans and any specific changes proposed for commissioning arrangements;
  - b) ensuring that, as part of any of our processes for potential or actual changes to commissioning arrangements, appropriate advice is obtained with regard to the relevant aspects of prevention, diagnosis and treatment of individual patients and/or the protection and improvement of public health in the community;
  - c) requiring our performance in achieving (b) above to be monitored by the Audit and Governance Committee.
- 5.2.10. *Promote innovation*<sup>31</sup> by:
- a) delegating responsibility for delivering this duty to the Executive Nurse and providing he/she with support from other appropriate health professionals;

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<sup>28</sup> See section 14U of the 2006 Act, inserted by section 26 of the 2012 Act

<sup>29</sup> See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act

<sup>30</sup> See section 14W of the 2006 Act, inserted by section 26 of the 2012 Act

<sup>31</sup> See section 14X of the 2006 Act, inserted by section 26 of the 2012 Act

- b) requiring the Executive Nurse to prepare an annual report to the governing body on how the group has promoted innovation in the provision of health services during the previous year.

5.2.11. *Promote research and the use of research*<sup>32</sup> by:

- a) delegating responsibility for delivering this duty to the Executive Nurse and providing he/she with support from other appropriate health professionals;
- b) requiring the Executive Nurse to prepare an annual report to the governing body on how the group has promoted relevant research and the use of evidence obtained from research during the previous year.

5.2.12. Have regard to the need to *promote education and training*<sup>33</sup> for persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England so as to assist the Secretary of State for Health in the discharge of his related duty<sup>34</sup> by:

- a) delegating responsibility for delivering this duty to the Executive Nurse; and providing them with support from other appropriate health professionals;
- b) requiring the Executive Nurse to prepare an annual report to the governing body on how the group has promoted relevant education and training during the previous year.

5.2.13. Act with a view to *promoting integration* of both health services with other health services and health services with health-related and social care services where the group considers that this would improve the quality of services or reduce inequalities<sup>35</sup> by:

- a) delegating responsibility for delivering this duty to the Accountable Officer, who will be required to ensure consistency with the related duties at 5.1.2(c), 5.2.4 and 5.2.6 above;
- b) requiring the Accountable Officer to prepare an annual report to the governing body on how the group has promoted integration in order to improve quality and reduce inequalities with regard to access to services and outcomes during the previous year.

**5.3. General Financial Duties** – the group will perform its functions so as to:

5.3.1. *Ensure its expenditure does not exceed the aggregate of its allotments for the financial year*<sup>36</sup> by

- a) delegating responsibility for delivering this duty to the Chief Finance Officer;
- b) establishing a Finance and Performance Committee to support the Chief Finance Officer in meeting that responsibility within a financial framework that gives priority to the quality of service provision;

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<sup>32</sup> See section 14Y of the 2006 Act, inserted by section 26 of the 2012 Act

<sup>33</sup> See section 14Z of the 2006 Act, inserted by section 26 of the 2012 Act

<sup>34</sup> See section 1F(1) of the 2006 Act, inserted by section 7 of the 2012 Act

<sup>35</sup> See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act

<sup>36</sup> See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act

- c) using our Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies as the policy framework through which this duty will be delivered;
- d) documenting accounting and budgetary control processes that enable all officers and employees of the group to comply with this policy framework;
- e) requiring our performance in delivery of this duty to be monitored by the Audit and Governance Committee.

5.3.2. *Ensure its use of resources (both its capital resource use and revenue resource use) does not exceed the amount specified by NHS England for the financial year<sup>37</sup> by*

- a) delegating responsibility for delivering this duty to the Chief Finance Officer;
- b) establishing a Finance and Performance Committee to support the Chief Finance Officer in meeting that responsibility;
- c) using our Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies as the policy framework through which this duty will be delivered;
- d) documenting accounting, resource control and budgetary control processes that enable all officers and employees of the group to comply with this policy framework;
- e) requiring our performance in delivery of this duty to be monitored by the Audit and Governance Committee.

5.3.3. *Take account of any directions issued by NHS England , in respect of specified types of resource use in a financial year, to ensure the group does not exceed an amount specified by NHS England <sup>38</sup> by*

- a) delegating responsibility for delivering this duty to the Chief Finance Officer;
- b) establishing a Finance and Performance Committee to support the Chief Finance Officer in meeting that responsibility;
- c) using our Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies as the policy framework through which this duty will be delivered;
- d) documenting accounting, resource control and budgetary control processes that enable all officers and employees of the group to comply with this policy framework;
- e) requiring our performance in delivery of this duty to be monitored by the Audit and Governance Committee.

5.3.4. *Publish an explanation of how the group spent any payment in respect of quality made to it by NHS England <sup>39</sup> by*

- a) delegating responsibility for delivering this duty to the Chief Finance Officer, who will be required to ensure that it is achievable by virtue of meeting the duties at 5.3.1 to 5.3.3 above

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<sup>37</sup> See sections 223I(2) and 223I(3) of the 2006 Act, inserted by section 27 of the 2012 Act

<sup>38</sup> See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act

<sup>39</sup> See section 223K(7) of the 2006 Act, inserted by section 27 of the 2012 Act

- b) requiring the Chief Finance Officer to prepare an annual report to the governing body on how the group has spent any funds received from NHS England in respect of quality.

#### **5.4. Other Relevant Regulations, Directions and Documents**

5.4.1. The group will

- a) comply with all relevant regulations;
- b) comply with directions issued by the Secretary of State for Health or NHS England; and
- c) take account, as appropriate, of documents issued by NHS England.

5.4.2. The group will develop and implement the necessary systems and processes to comply with these regulations and directions, documenting them as necessary in this constitution, its Scheme of Reservation and Delegation and other relevant group policies and procedures.

### **6. DECISION MAKING: THE GOVERNING STRUCTURE**

#### **6.1. Authority to act**

6.1.1. The clinical commissioning group is accountable for exercising the statutory functions of the group. It may grant authority to act on its behalf to:

- a) any of its members;
- b) its governing body;
- c) employees;
- d) a committee or sub-committee of the group.

6.1.2. The extent of the authority to act of the respective bodies and individuals depends on the powers delegated to them by the group as expressed through:

- a) the group's Scheme of Reservation and Delegation; and
- b) for committees, their Terms of Reference.

#### **6.2. Scheme of Reservation and Delegation<sup>40</sup>**

6.2.1. The group's Scheme of Reservation and Delegation sets out:

- a) those decisions that are reserved for the membership as a whole;

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<sup>40</sup> See Appendix F

- b) those decisions that are the responsibilities of its governing body (and its committees), the group's committees and sub-committees, individual members and employees.

6.2.2. The clinical commissioning group remains accountable for all of its functions, including those that it has delegated.

### **6.3. General**

6.3.1. In discharging functions of the group that have been delegated to them, the governing body (and its committees), committees, joint committees, sub committees and individuals must:

- a) comply with the group's principles of good governance,<sup>41</sup>
- b) operate in accordance with the group's Scheme of Reservation and Delegation,<sup>42</sup>
- c) comply with the group's Standing Orders,<sup>43</sup>
- d) comply with the group's arrangements for discharging its statutory duties,<sup>44</sup>
- e) where appropriate, ensure that member practices have had the opportunity to contribute to the group's decision making process.

6.3.2. When discharging their delegated functions, committees, sub-committees and joint committees must also operate in accordance with their approved terms of reference.

6.3.3. Where delegated responsibilities are being discharged collaboratively, the joint (collaborative) arrangements will:

- a) identify the roles and responsibilities of those clinical commissioning groups who are working together and the responsibilities delegated by each group to the individuals representing them;
- b) identify any pooled budgets and how these will be managed and reported in annual accounts;
- c) specify under which clinical commissioning group's Scheme of Reservation and Delegation and supporting policies the collaborative working arrangements will operate;
- d) specify how the risks associated with the collaborative working arrangement will be managed between the respective parties;

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<sup>41</sup> See section 4.4 on Principles of Good Governance above

<sup>42</sup> See Appendix F

<sup>43</sup> See Appendix E

<sup>44</sup> See chapter 5 above

- e) identify how disputes will be resolved and the steps required to terminate the working arrangements;
- f) specify how decisions are communicated to the collaborative partners.

#### **6.4. Committees of the group and/or governing body**

6.4.1. The group has not established any committees. The following committees have been established by the governing body:-

- The Audit and Governance Committee;
- Remuneration Committee;
- Quality and Safety Committee;
- Finance and Performance Committee; and
- Commissioning Committee
- Primary Care Commissioning Committee

6.4.2. Committees will only be able to establish their own sub-committees, to assist them in discharging their respective responsibilities, if this responsibility has been delegated to them by the group or governing body to which the committee is accountable and the group or governing body has approved the sub-committee's Terms of Reference.

#### **6.5. Joint commissioning arrangements with other Clinical Commissioning Groups**

6.5.1. The Group may wish to work together with other CCGs in the exercise of its commissioning functions.

6.5.2. The Group may make arrangements with one or more CCG in respect of:

- a) delegating any of the Group's commissioning functions to another CCG;
- b) exercising any of the commissioning functions of another CCG; or
- c) exercising jointly the commissioning functions of the Group and another CCG

6.5.3. For the purposes of the arrangements described at paragraph 6.5.2, the Group may:

- a) make payments to another CCG;
- b) receive payments from another CCG;
- c) make the services of its employees or any other resources available to another CCG; or
- d) receive the services of the employees or the resources available to another CCG.

6.5.4. Where the Group makes arrangements which involve all the CCGs exercising any of their commissioning functions jointly, a joint committee may be established to exercise those functions.

6.5.5. For the purposes of the arrangements described at paragraph 6.5.2 above, the Group may establish and maintain a pooled fund made up of contributions by any of the CCGs working together pursuant to paragraph 6.5.3 above. Any such



pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

- 6.5.6. Where the Group makes arrangements with another CCG as described at paragraph 6.5.2 above, the Group shall develop and agree with that CCG an agreement setting out the arrangements for joint working, including details of:
- a) How the parties will work together to carry out their commissioning functions;
  - b) The duties and responsibilities of the parties;
  - c) How risk will be managed and apportioned between the parties;
  - d) Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;
  - e) Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.
- 6.5.7. The liability of the Group to carry out its functions will not be affected where the Group enters into arrangements pursuant to paragraph 6.5.2 above.
- 6.5.8. The Group will act in accordance with any further guidance issued by NHS England on co-commissioning.
- 6.5.9. Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.
- 6.5.10. The governing body of the Group shall require, in all joint commissioning arrangements, that the lead clinician and lead manager of the lead CCG make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.
- 6.5.11. Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the Group can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the next new financial year.
- 6.5.12. The CCG has established a Joint Commissioning Committee with NHS Dudley, NHS Sandwell and West Birmingham and NHS Walsall CCGs to exercise the functions set out in the Committee's Terms of Reference and in line with the CCG's Scheme of Reservation and Delegation. The Terms of Reference are appended to (but are not part of) this Constitution.

## **6.6. Joint commissioning arrangements with NHS England for the exercise of CCG functions**

- 6.6.1. The Group may wish to work together with NHS England in the exercise of its commissioning functions.
- 6.6.2. The Group and NHS England may make arrangements to exercise any of the Group's commissioning functions jointly.
- 6.6.3. The arrangements referred to in paragraph 6.6.2 above may include other CCGs.

- 6.6.4. Where joint commissioning arrangements pursuant to 6.6.2 above are entered into, the parties may establish a joint committee to exercise the commissioning functions in question.
- 6.6.5. Arrangements made pursuant to 6.6.2 above may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the Group.
- 6.6.6. Where the Group makes arrangements with NHS England (and another CCG if relevant) as described at paragraph 6.6.2 above, the Group shall develop and agree with NHS England a framework setting out the arrangements for joint working, including details of:
- a) How the parties will work together to carry out their commissioning functions;
  - b) The duties and responsibilities of the parties;
  - c) How risk will be managed and apportioned between the parties;
  - d) Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;
  - e) Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements; and
- 6.6.7. The liability of the Group to carry out its functions will not be affected where the Group enters into arrangements pursuant to paragraph 6.6.2 above.
- 6.6.8. The Group will act in accordance with any further guidance issued by NHS England on co-commissioning.
- 6.6.9. Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.
- 6.6.10. The governing body of the Group shall require, in all joint commissioning arrangements that the Director of Strategy and Transformation make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.
- 6.6.11. Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the Group can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months' notice period.
- 6.7. Joint commissioning arrangements with NHS England for the exercise of NHS England's functions**
- 6.7.1. The Group may wish to work with NHS England and, where applicable, other CCGs, to exercise specified NHS England functions.
- 6.7.2. The Group may enter into arrangements with NHS England and, where applicable, other CCGs to:

- a) Exercise such functions as specified by NHS England under delegated arrangements;
  - b) Jointly exercise such functions as specified with NHS England.
- 6.7.3. Where arrangements are made for the Group and, where applicable, other CCGs to exercise functions jointly with NHS England a joint committee may be established to exercise the functions in question.
- 6.7.4. Arrangements made between NHS England and the CCG may be on such terms and conditions (including terms as to payment) as may be agreed between the parties.
- 6.7.5. For the purposes of the arrangements described at paragraph 6.7.2 above, NHS England and the Group may establish and maintain a pooled fund made up of contributions by the parties working together. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.
- 6.7.6. Where the Group enters into arrangements with NHS England as described at paragraph 6.7.2 above, the parties will develop and agree a framework setting out the arrangements for joint working, including details of:
- a) How the parties will work together to carry out their commissioning functions;
  - b) The duties and responsibilities of the parties;
  - c) How risk will be managed and apportioned between the parties;
  - d) Financial arrangements, including payments towards a pooled fund and management of that fund;
  - e) Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.
- 6.7.7. The liability of NHS England to carry out its functions will not be affected where it and the Group enter into arrangements pursuant to paragraph 6.7.2 above.
- 6.7.8. The Group will act in accordance with any further guidance issued by NHS England on co-commissioning.
- 6.7.9. Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.
- 6.7.10. The governing body of the Group shall require, in all joint commissioning arrangements that the Director of Strategy and Transformation make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.
- 6.7.11. Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the Group can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months' notice period.

## **6.8. Joint Arrangements with the Local Authority**

- 6.8.1. The group may form collaborative arrangements with Wolverhampton City Council in order to manage pooled budgets and make delegated decisions under Section 75 of the 2006 Act.

## 6.9. The Governing Body

- 6.9.1. *Functions* - the governing body has the following functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act, together with any other functions connected with its main functions as may be specified in regulations or in this constitution.<sup>45</sup> The governing body may also have functions of the clinical commissioning group delegated to it by the group. Where the group has conferred additional functions on the governing body connected with its main functions, or has delegated any of the group's functions to its governing body, these are set out from paragraph 6.9.1(d) below. The governing body has responsibility for:

- a) ensuring that the group has appropriate arrangements in place to exercise its functions *effectively, efficiently and economically* (see 5.2.3 above) and in accordance with the group's *principles of good governance*<sup>46</sup> (its main function);
- b) approving any functions of the group that are specified in regulations;<sup>47</sup>
- c) leading the setting of vision and strategy, approving budgets and commissioning plans (Prime Financial Policy 7), monitoring performance against budgets, plans and contracts (PFP 14), providing assurance with regard to strategic risk management (PFP 15.3);
- d) delivering the group's duty with regard to commissioning health services consistently with the duty of the Secretary of State and NHS England to promote a comprehensive health service and the objectives and requirements placed on NHS England through the Secretary of State's mandate (see 5.1.2(a) above);
- e) approving the group's detailed scheme of delegation, operating structure, annual report and accounts, any grants and loans to voluntary organisations (PFP 12.1(e)(i));
- f) agreeing changes to the terms of reference of its committees, other than with regard to membership, prior to their inclusion in an application to NHS England;
- g) deciding to ratify any reported non-compliance with Standing Orders or upon the course of action required as a result of it (Standing Order 5).

- 6.9.2. *Composition of the Governing Body* - the governing body will comprise the following 15 members:

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<sup>45</sup> See section 14L(3)(c) of the 2006 Act, as inserted by section 25 of the 2012 Act

<sup>46</sup> See section 4.4 on Principles of Good Governance above

<sup>47</sup> See section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act

- a) the chair, who will be an elected GP, appointed to a three year term (subject to re-election) by the members of the group;
- b) Six other GPs, who shall be their practices representatives, elected by member practices to ensure that groupings of primary care in Wolverhampton are represented in proportion with the patient list of practices within each group at the point the election takes place. Clinical leads for Finance and Performance, Commissioning and Contracting and Quality and Safety will be appointed from amongst these GPs;
- c) two lay members as defined by regulations, one of whom will chair the Remuneration Committee:
  - i) one with qualifications, expertise or experience enabling them to express informed views about financial management, conflicts of interests and audit matters, who will chair the Audit and Governance Committee;
  - ii) one who has knowledge about the City of Wolverhampton enabling them to express informed views about the discharge of the Group's functions, who will be deputy chair, the governing body lead for Equality and Diversity and Chair the Primary Care Commissioning Committee;
- d) A lay member with knowledge of Finance and Performance matters who will chair the Finance and Performance Committee and act as deputy chair of the Primary Care Commissioning Committee.
- e) one registered nurse who will be employed as the group's Executive Nurse;
- f) one secondary care specialist doctor;
- g) the Accountable Officer who will be employed as the group's Chief Officer and will act as the group's Caldicott Guardian;
- h) the Chief Finance Officer, an individual with a recognised accountancy qualification and will act as the group's Senior Information Risk Owner;
- i) the group's Director for Strategy and Transformation;
- j) the group's Director of Operations
- k) one practice manager representative.

The group's Standing Orders define how the group will, in accordance with any relevant regulations, appoint the various categories of members of the governing body, their tenure of office, how a person would resign from their post and the grounds for their removal from office. They also specify those persons who will be invited to attend meetings of the governing body as well as the arrangements for admission of the public and press.

6.9.3 *Committees of the Governing Body* - the governing body has appointed the following committees:

(a) the *Audit and Governance Committee*, which is accountable to the governing body and provides it with an independent and objective view of the group's financial systems, financial information and compliance with laws, regulations and directions governing the group, so far as they relate to finance and governance. The governing body has approved and annually reviews the terms of reference for the committee, which include information on its membership<sup>48</sup>. In addition the group or the governing body has conferred upon or delegated the following functions, connected with the governing body's main function<sup>49</sup>, to the Audit and Governance Committee:

- i) reviewing the group's adherence to the generally accepted principles of good governance (4.4.1 above);
- ii) monitoring the group's performance in delivering the duty to act effectively, efficiently and economically (5.2.3 above);
- iii) monitoring the group's performance in the delivery of the duties described at 5.1.2(a), 5.2.9 and the general financial duties at 5.3.1 – 5.3.3;
- iv) reviewing the reasonableness of any decision to suspend Standing Orders (SO 3.9), considering reports on non-compliance with Prime Financial Policies (PFP 1.2.1) and scrutinising any proposed changes thereto (PFP 1.5.1);
- v) reviewing the group's arrangements to manage all risks and receive appropriate assurance thereon through an integrated governance framework<sup>50</sup>;
- vi) satisfying itself that there is an effective internal audit service (PFP 3) and adequate arrangements for countering fraud (PFP 4), reviewing the work and findings of the external auditors, approving any changes to the provision or delivery of assurance services (PFP 3.4 (b));
- vii) reviewing the annual report and financial statements before submission to the governing body and group.

(b) the *Remuneration Committee*, which is accountable to the governing body and makes binding and final determinations about the remuneration, fees and other allowances for employees and for people who provide services to the group and on determinations about allowances under any pension scheme that the group may establish as an alternative to the NHS pension scheme. The governing body has approved and keeps under review the terms of reference for the committee, which include information on its membership<sup>51</sup>. In addition, the group or the governing body has conferred or delegated the following functions, connected with the governing body's main function, to the Remuneration Committee:

- i) determining the remuneration, fees and other allowances payable to group and governing body members, employees or other persons providing

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<sup>48</sup> See Appendix H1 Terms of Reference of the Audit and Governance Committee

<sup>49</sup> See section 14L(2) of the 2006 Act, inserted by section 25 of the 2012 Act

<sup>50</sup> NHS Audit Committee Handbook, Department of Health / Healthcare Financial Management Association, 2011

<sup>51</sup> See Appendix H2 Terms of Reference of the Remuneration Committee

services to the group, including the remuneration and conditions of service of the senior team and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act;

- ii) determining the performance, remuneration and terms and conditions of the Accountable Officer and other senior team members and determining annual salary awards, if appropriate.
- iii) considering any severance payments of the Accountable Officer and other senior staff, seeking HM Treasury approval as appropriate in accordance with the guidance 'Managing Public Money' (available on the HM Treasury.gov.uk website);
- iv) approving human resources policies (9.4 below);and ,
- v) approving the group's terms and conditions and remuneration of employees and those providing services to the group.

(c) the *Quality and Safety Committee*, which is accountable to the governing body and provides it with assurance on the quality of services commissioned and monitors on its behalf the group's performance in the delivery of the duties described at 5.1.2(b), 5.2.1, 5.2.2, 5.2.4, 5.2.5, 5.2.7 and 5.2.8. The governing body has approved and keeps under review the terms of reference for the committee, which include information on its membership<sup>52</sup>. In addition the group or the governing body has conferred or delegated the following functions, connected with the governing body's main function, to the Quality and Safety Committee:

- i) receiving reports from the group's representative on the Wolverhampton Health and Wellbeing Board (see 5.1.2 (c)(ii) above);
- ii) approving policies for risk management including assurance (Prime Financial Policy 15.2), information governance (PFP 19.2), business continuity, emergency planning , security and complaints handling;
- iii) endorsing action plans to address high scoring risks in the group's risk register (PFP 15.4).

(d) the *Finance and Performance Committee*, which is accountable to the governing body and provides it with assurance on issues related to the finances and performance of the group and monitors on its behalf the group's performance in the delivery of the duties described at 5.2.3 and 5.2.6. The governing body has approved and keeps under review the Terms of Reference for the committee, which include information on its membership<sup>53</sup>. In addition the group or the governing body has conferred or delegated the following functions, connected with the governing body's main function, to the Finance and Performance Committee:

- i) supporting the Chief Finance Officer in the delivery of the general financial duties (5.3.1 -5.3.3 above);
- ii) receiving reports from the group's representative on the Wolverhampton Health and Wellbeing Board (see 5.1.2 (c)(ii) above);

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<sup>52</sup> See Appendix H3 Terms of Reference of the Quality and Safety Committee

<sup>53</sup> See Appendix H4 Terms of Reference of the Finance and Performance Committee

- iii) reviewing proposed changes to Prime Financial Policies (PFP 1.5.1) and approving detailed financial policies (PFP 1.1.3);
- iv) considering reports from the Chief Finance Officer and other managers regarding significant variances from budgeted performance (PFP7.3) and planned performance targets respectively;
- v) agreeing the timetable for producing the annual accounts and report (PFP8.1(a));
- vi) approving the group's overall banking arrangements (PFP 11.2);
- vii) receiving reports detailing actual and forecast expenditure and activity for all healthcare contracts (PFP 14.3).

(e) the *Commissioning Committee*, which is accountable to the governing body and will support it, the Director of Strategy and Transformation and the Executive Nurse in meeting the responsibilities of the group as a commissioner of healthcare, specifically delivery of the duties described at 5.1.2(a) and 5.2.4. The governing body has approved and keeps under review the Terms of Reference for the committee, which include information on its membership<sup>54</sup>. In addition the group or the governing body has conferred or delegated the following functions, connected with the governing body's main function, to the Commissioning Committee:

- i) developing appropriate policies, strategies and plans;
- ii) co-ordinating the work of the group with other parties in order to develop robust commissioning plans (PFP 14.1).

(f) the *Primary Care Commissioning Committee*, which is accountable to the governing body for the exercise of the functions delegated to the group by NHS England relating to the commissioning of primary medical services under Section 86 of the NHS Act 2006.

## **7. ROLES AND RESPONSIBILITIES**

### **7.1. Practice Representatives**

7.1.1. Practice representatives will be GPs or other healthcare professionals who represent their practice's views and act on behalf of the practice in matters relating to their specific locality and the group as a whole. The role of each practice representative is to assist the group in securing the effective participation of each member of the group in exercising the group's functions by:

- a) providing effective liaison between the practice and the rest of the locality and group;
- b) promoting the work of the locality and group within the practice and to its patients as far as possible;
- c) actively seeking the views of the practice and its patients and providing feedback to the rest of the locality and group;
- d) arranging for the implementation of agreed locality and group directives within the practice or informing the rest of the locality and group as soon as possible of any obstacles to doing so;

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<sup>54</sup> See Appendix H5 Terms of Reference of the Commissioning Committee



- e) attending meetings of the locality and group so that the practice is represented and its voice heard, or ensuring that a deputy does so.

Details as to how practice representatives will be selected are included in the group's Standing Orders, which also specify the officer of the group that practices must inform as to who their representative is.

## **7.2. Other GPs and Primary Care Health Professionals**

7.2.1. In addition to the practice representatives identified in section 7.1 above, the group has identified a number of other GPs/primary care health professionals from member practices to support the work of the group and/or represent the group rather than represent their own individual practices. These GPs and primary care health professional undertake the following roles on behalf of the group, reporting in each case to the member of the governing body with responsibility for the particular work area:

- a) developing proposals for changes to care pathways;
- b) developing proposals for other significant changes to the group's commissioning portfolio;
- c) monitoring a provider's delivery against its contract with the group in terms of activity or quality;
- d) liaising with practices and consulting with patients/carers in support of these activities;
- e) education and research in support of these activities.

## **7.3. All Members of the Group's Governing Body**

7.3.1. Guidance on the roles of members of the group's governing body is set out in a separate document<sup>55</sup>. In summary, each member of the governing body should share responsibility as part of a team to ensure that the group exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of this constitution. Each brings their unique perspective, informed by their expertise and experience.

7.3.2. All members will be able to demonstrate the leadership skills necessary to fulfil the responsibilities of these key roles and establish credibility with all stakeholders and partners. Especially important is that the governing body remains in tune with the group's member practices and secures their confidence and engagement.

## **7.4. The Chair of the Governing Body**

7.4.1. The Chair of the governing body is responsible for:

- a) leading the governing body, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this constitution;
- b) building and developing the group's governing body and its individual members;

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<sup>55</sup> *Clinical commissioning group Governing Body Members – Role outlines, Attributes and Skills*, NHS Commissioning Board, October 2012

- c) ensuring that the group has proper constitutional and governance arrangements in place;
- d) ensuring that, through the appropriate support, information and evidence, the governing body is able to discharge its duties;
- e) supporting the accountable officer in discharging the responsibilities of the organisation;
- f) contributing to building a shared vision of the aims, values and culture of the organisation;
- g) leading and influencing to achieve clinical and organisational change to enable the group to deliver its commissioning responsibilities;
- h) overseeing governance and particularly ensuring that the governing body and the wider group behaves with the utmost transparency and responsiveness at all times;
- i) ensuring that public and patients' views are heard and their expectations understood and, where appropriate as far as possible, met;
- j) ensuring that the organisation is able to account to its local patients, stakeholders and NHS England;
- k) ensuring that the group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from Wolverhampton City Council.

## **7.5. The Deputy Chair of the Governing Body**

- 7.5.1. The Deputy Chair of the governing body deputises for the Chair of the governing body where he or she has a conflict of interest or is otherwise unable to act.
- 7.5.2. Details of how they will be appointed, their tenure of office and resignation or removal are included in the group's Standing Orders.

## **7.6. Role of the Accountable Officer**

- 7.6.1. The Accountable Officer of the group is a member of the governing body.
- 7.6.2. This role of Accountable Officer has been summarised in a national document<sup>56</sup> and this is reflected in (a) to (c) below:

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<sup>56</sup> See the latest version of the NHS Commissioning Board Authority's *Clinical commissioning group governing body members: Role outlines, attributes and skills*

- a) being responsible for ensuring that the clinical commissioning group fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money;
- b) at all times ensuring that the regularity and propriety of expenditure is discharged and that arrangements are put in place to ensure that good practice (as identified through the relevant agencies and, in particular, the auditors of the group) is embodied and that safeguarding of funds is ensured through effective financial and management systems;
- c) working closely with the Chair of the governing body, the Accountable Officer will ensure that proper constitutional, governance and development arrangements are put in place to assure the members (through the governing body) of the organisation's ongoing capability and capacity to meet its duties and responsibilities. This will include arrangements for the ongoing developments of its members and staff.
- d) the group has specifically delegated responsibility to the Accountable Officer for the delivery of its duties as described at 5.1.2(b), 5.2.1, 5.2.2, 5.2.5, 5.2.6 and 5.2.8 and for the role of Caldicott Guardian.

## **7.7. Role of the Chief Finance Officer**

7.7.1. The Chief Finance Officer is a member of the governing body and is responsible for providing financial advice to the clinical commissioning group and for supervising financial control and accounting systems.

7.7.2. This role of the Chief Finance Officer has been summarised in a national document<sup>57</sup> and this is reflected in (a) to (e) below:

- a) being the governing body's professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged;
- b) making appropriate arrangements to support, monitor and report on the group's finances;
- c) overseeing robust audit and governance arrangements leading to propriety in the use of the group's resources;
- d) being able to advise the governing body on the effective, efficient and economic use of the group's allocation to remain within that allocation and deliver required financial targets and duties; and
- e) producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to NHS England;

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<sup>57</sup> See the latest version of the NHS Commissioning Board Authority's *Clinical commissioning group governing body members: Role outlines, attributes and skills*

- f) the group has accordingly delegated responsibility to the Chief Finance Officer for the delivery of its financial duties described at 5.3 above and as the Senior Information Risk Owner.

## **7.8. Joint Appointments with other Organisations**

- 7.8.1. The Group's Chief Finance Officer is a joint appointment with NHS Walsall CCG.

## **7.9. Responsibilities of member practices to the group and of the group to its member practices**

- 7.9.1. The group is a membership organisation and the effective participation of each and every member practice will be essential in developing and sustaining cost effective commissioning arrangements that ensure high quality services for all relevant patients and service users.

- 7.9.2. Each member practice will:

- a) appoint a practice representative in line with 7.1 above and Standing Order 2.2.5;
- b) undertake regular, at least quarterly, practice meetings to monitor performance against the commissioning indicators as set out in the group's commissioning performance reports;
- c) meet with the relevant locality chair and/or GP engagement lead and agree plans to support delivery of the group's commissioning strategies;
- d) support the relevant locality board and group's commissioning intentions and strategies by using, as appropriate and in accordance with patient choice, services and pathways as commissioned by the group;
- e) access relevant commissioning information including that relating to pathways and referral guidelines via agreed group systems;
- f) take all reasonable efforts to ensure that it remains within its commissioning budget;
- g) support the relevant, locality board and the group in meeting its quality and productivity targets as set out within the group's commissioning strategies;
- h) take account of all duties, rights, pledges and values set out in this constitution;
- i) respond in a timely manner to reasonable information requests from the group.

- 7.9.3. The group will ensure that:

- a) all member practices receive at least one visit each year from representatives of the group to discuss practice level commissioning issues and priorities;
- b) an annual survey of practices, designed and administered in conjunction with the Local Medical Committee (LMC), is undertaken to obtain feedback on levels of satisfaction regarding practice involvement in the commissioning process;
- c) member practices are kept informed of group business via their practice representatives and relevant locality board chair, the intranet site, specific events and other appropriate means;
- d) the governing body provides information management tools, training and support to enable member practices to review information at patient level and support them in meeting their financial and quality targets.

## **7.10. Dispute Resolution Processes**

7.10.1. This process will be used promptly, in a supportive and constructive manner, in the event of any dispute or disagreement being raised by:

- a) member practices, regarding the governing body or general workings of the group;
- b) the governing body and/or the rest of the group in relation to the behaviour of any member practice.

7.10.2. Member practices should, in the normal course of events, be able to raise any contentious issue with their relevant locality board chair or deputy chair, or if this is not possible, with another member of the governing body. In circumstances where this informal contact does not resolve the issue satisfactorily, the following process will be followed:

- a) the practice will set out the issue in writing and submit this to the Accountable Officer;
- b) the Accountable Officer will acknowledge receipt within ten working days unless the issue appears extremely urgent, in which case, the matter will be progressed with the utmost urgency;
- c) the Chair and/or Accountable Officer will contact the practice to discuss the matter, involving those with relevant lead responsibilities within the group as appropriate, and agree in writing appropriate actions for resolution with a time-scale for actions by all involved parties;
- d) if this fails to resolve the issue, the matter will be referred to a lay member of the governing body, who will be responsible for leading consideration of the matter in private session at a governing body meeting to which the practice will be able to make direct representation of its position and at which appropriate actions for resolution will be minuted;

- e) if the matter still cannot be resolved, it will be referred by the member practice and/or the governing body to NHS England for a binding arbitration;
- f) a member practice can involve the LMC or other external support, except legal representation, at any stage of this process.

7.10.3. In the normal course of events, any issues regarding a member practice's non-compliance with its responsibilities as a member of the group will be raised via routine reporting arrangements and discussion with the relevant locality board chair. When such issues cannot be resolved via this normal day to day contact, the following process will be followed:

- a) on behalf of the governing body, the Chair of the governing body or Accountable Officer will set out the issue in writing and send this to the member practice;
- b) the practice will acknowledge receipt within ten working days unless the issue appears extremely urgent, in which case, the matter will be progressed with the utmost urgency
- c) the practice will be asked to meet with the Chair of the governing body and/or Accountable Officer to discuss the issue, involving those with relevant lead responsibilities within the group as appropriate, and put in writing appropriate actions against an agreed timescale;
- d) the group will ensure that the member practice is provided with the appropriate information and assistance to support it in delivering the agreed plan;
- e) if this approach fails to resolve the issue or the practice fails to deliver the actions agreed to address the non-compliance to the satisfaction of the governing body (meeting in private), the issue will be escalated to NHS England whose decision on the matter will be final;
- f) a member practice can involve the LMC or other external support, except legal representation, at any stage of this process.

## **8. STANDARDS OF BUSINESS CONDUCT AND MANAGING CONFLICTS OF INTEREST**

### **8.1. Standards of Business Conduct**

8.1.1. Employees, members, committee and sub-committee members of the group and members of the governing body and its committees will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should act in good faith and in the interests of the group and should follow the Seven Principles of Public Life, set out by the Committee on Standards in Public Life (the Nolan Principles) The Nolan Principles are incorporated into this constitution at Appendix C.

- 8.1.2. They must comply with the group’s policy on business conduct, including the requirements set out in the policy for meeting the group’s duties with regard to registering interests and managing conflicts of interest.<sup>58</sup> This policy will be available on the group’s website at [www.wolverhamptonccg.nhs.uk](http://www.wolverhamptonccg.nhs.uk), available for inspection at the group’s offices, and either by post or email on request.
- 8.1.3. Individuals contracted to work on behalf of the group or otherwise providing services or facilities to the group will be made aware of their obligation with regard to declaring actual or potential conflicts of interest. This requirement will be written into their contract for services.
- 8.1.4. Due consideration will be given to the available guidelines, protocols and the manner in which conflicts of interest are managed by statutory bodies, recognised national institutions such as the General Medical Council, General Practitioners Committee of the British Medical Association and, the Royal College of General Practitioners , and if appropriate, the group’s policy amended from time-to-time to reflect these.

## 8.2. Conflicts of Interest

- 8.2.1. As required by section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act, the group has made arrangements to manage actual and potential conflicts of interest to ensure that decisions made by the group will be taken and be seen to be taken without any possibility of the influence of external or private interest; the group maintains a register recording these
- 8.2.2. Where an individual, i.e. an employee, group member, member of the governing body, or a member of a committee or a sub-committee of the group or its governing body has an interest, or becomes aware of an interest, which could lead to a conflict of interest in the event of the group considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this constitution.
- 8.2.3. A conflict of interest will include:
- a) **Financial Interests:** where an individual or somebody with whom they have a close association may financially benefit from the consequences of a commissioning decision (for example, as a provider of services);
  - b) **Non- Financial Professional Interests –** where an individual or somebody with whom they have a close association may obtain a non-financial professional benefit from the consequences of a group decision, such as increasing their professional reputation or status or promoting their professional career;
  - c) **Non-Financial Personal Interests –** where an individual or somebody with whom they have a close association may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit (for example, a reconfiguration of hospital services

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<sup>58</sup> In accordance with Section 14O of the 2006 Act, inserted by Section 25 of the 2012 Act

which might result in the closure of a busy clinic next door to an individual's house);;

- 8.2.4. If in doubt, the individual concerned should assume that a potential conflict of interest exists and notify the CCG's Governance Lead or Conflicts of Interest Guardian (The Chair of the Audit and Governance Committee) accordingly.

### **8.3. Declaring and Registering Interests**

- 8.3.1. The group will maintain one or more registers of the interests of:

- a) the members of the group;
- b) the members of its governing body;
- c) the members of its committees or sub-committees and the committees or sub-committees of its governing body; and
- d) its employees.

- 8.3.2. The registers are to be published on the group's website at [www.wolverhamptonccg.nhs.uk](http://www.wolverhamptonccg.nhs.uk). Upon request, these will also be available at the group's Head Office or, on application by post or email.

- 8.3.3. Individuals will declare any interest that they have, in relation to a decision to be made in the exercise of the commissioning functions of the group, in writing to the governing body, as soon as they are aware of it and in any event no later than 28 days after becoming aware.

- 8.3.4. Where an individual is unable to provide a declaration in writing, for example, if a conflict becomes apparent in the course of a meeting, they will make an oral declaration before witnesses, and provide a written declaration as soon as possible thereafter.

- 8.3.5. The Conflict of Interest Guardian will ensure that the registers of interest are reviewed quarterly, and updated as necessary.

- 8.3.6. Prior to any appointment being made to the Governing Body, individuals will make a declaration of their interests in order to assess whether any identified conflicts would prevent the individual concerned making a full and proper contribution to the governing body. If such significant conflicts do exist, the individual concerned will be excluded from the appointment process.

### **8.4. Managing Conflicts of Interest: general**

- 8.4.1. Individual members of the group, the governing body, committees or sub-committees, the committees or sub-committees of its governing body and employees will comply with the arrangements determined by the group for managing actual or potential conflicts of interest.



- 8.4.2. The Conflict of Interest Guardian will ensure that for every interest declared, either in writing or by oral declaration, arrangements are in place to manage the conflict of interests or potential conflict of interests, to ensure the integrity of the group's decision making processes.
- 8.4.3. Arrangements for the management of conflicts of interest are to be determined by the lay member identified at 8.3.5 and will include the requirement to put in writing to the relevant individual arrangements for managing the actual or potential conflict within a week of declaration. The arrangements will confirm the following:
- a) when an individual should withdraw from a specified activity, on a temporary or permanent basis;
  - b) monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.
- 8.4.4. Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity connected with the group's exercise of its commissioning functions, they have received confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the Conflict of Interest Guardian.
- 8.4.5. Where an individual member, employee or person providing services to the group is aware of an interest which:
- a) has not been declared, either in the register or orally, they will declare this at the start of the meeting;
  - b) has previously been declared, in relation to the scheduled or likely business of the meeting, the individual concerned will bring this to the attention of the chair of the meeting, together with details of arrangements which have been confirmed for the management of the actual or potential conflict of interest(s);

The chair of the meeting will then determine how this should be managed and inform the member of their decision. Where no arrangements have been confirmed, the chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual will then comply with these arrangements, which must be recorded in the minutes of the meeting. The Chair's determination in relation to action to be taken in relation to a conflict arising, shall be final.

- 8.4.6. Where the chair of any meeting of the group, including committees, sub-committees, or the governing body and the governing body's committees and sub-committees, has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the deputy chair will act as chair for the relevant part of the meeting. Where arrangements have been confirmed for the management of the actual or potential conflict of interest in relation to the chair, the meeting must

ensure these are followed. Where no arrangements have been confirmed, the deputy chair may require the chair to withdraw from the meeting or part of it. Where there is no deputy chair, the members of the meeting will select one.

- 8.4.7. Any declarations of interests, and arrangements agreed in any meeting of the clinical commissioning group, committees or sub-committees, or the governing body, the governing body's committees or sub-committees, will be recorded in the minutes.
- 8.4.8. Where more than 50% of the members of a meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of actual or potential conflicts of interest, the chair (or deputy) will determine whether or not the discussion can proceed.
- 8.4.9. In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the group's Standing Orders. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum could never be convened from the membership of the meeting, owing to the arrangements for managing actual or potential conflicts of interest, the chair of the meeting will consult with the lay member identified at 8.3.5 on the action to be taken.
- 8.4.10. This action might include:
- a) referring the matter to the group's governing body, its committees or sub-committees, which can be quorate to progress the item of business even if all the elected members and/or other members have to be excluded from voting (Standing Order 3.6.2);
  - b) inviting, on a temporary basis, one or more of the following to make up the quorum, i.e. those who do not have a conflict of interest, to attend the relevant part of the governing body's meeting to provide additional scrutiny to the matter and advice to those members of the governing body who can vote on it:
    - i) a practice representative; and/or
    - ii) an individual appointed by a member to act on his/her behalf in the dealing between it and the group
    - iii) a member of a relevant Health and Wellbeing Board;
    - iv) a member of a governing body of another clinical commissioning group.

These arrangements must be recorded in the relevant minutes.

- 8.4.11. In any transaction undertaken in support of the clinical commissioning group's exercise of its commissioning functions (including conversations between two or more individuals, e-mails, correspondence and other communications), individuals must ensure, where they are aware of an interest, that they conform to the arrangements confirmed for the management of that interest. Where an individual has not had confirmation of arrangements for managing the interest, they must declare their interest at the earliest possible opportunity in the course

of that transaction, and declare that interest as soon as possible thereafter. The individual must also inform either their line manager (in the case of employees), or the lay member identified at 8.3.5 of the transaction.

- 8.4.12. The Conflict of Interest Guardian will take such steps as deemed appropriate, and request information deemed appropriate from individuals, to ensure that all actual and potential conflicts of interest are declared and recorded.

## **8.5. Managing Conflicts of Interest: contractors and people who provide services to the group**

- 8.5.1. Anyone seeking information in relation to a procurement, or participating in a procurement, or otherwise engaging with the clinical commissioning group in relation to the potential provision of services or facilities to the group, will be required to make a declaration of any relevant actual or potential conflict of interest.

- 8.5.2. Anyone contracted to provide services or facilities directly to the clinical commissioning group will be subject to the same provisions of this constitution in relation to managing conflicts of interests. This requirement will be set out in the contract for their services.

## **8.6. Transparency in Procuring Services**

- 8.6.1. The group recognises the importance in making decisions about the services it procures in a way that does not call into question the motives behind the procurement decision that has been made. The group will procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers, using special designated procedures when GPs or their practices are potential providers or have an interest therein.

- 8.6.2. The group will publish a Procurement Strategy approved by its governing body which will ensure that:

- a) all relevant clinicians (not just members of the group) and potential providers, together with local members of the public, are engaged in the decision-making processes used to procure services;
- b) service redesign and procurement processes are conducted in an open, transparent, non-discriminatory and fair way

- 8.6.3. Copies of this Procurement Strategy will be available on the group's website at [www.wolverhamptonccg.nhs.uk](http://www.wolverhamptonccg.nhs.uk), available for inspection at the group's offices, and either by post or email, on request.

## **9. THE GROUP AS EMPLOYER**

- 9.1. The group recognises that its most valuable asset is its people. It will seek to enhance their skills and experience and is committed to their development in all ways relevant to the work of the group.

- 9.2. The group will seek to set an example of best practice as an employer and is committed to offering all staff equality of opportunity. It will ensure that its employment practices are designed to promote diversity and to treat all individuals equally.
- 9.3. The group will ensure that it employs suitably qualified and experienced staff who will discharge their responsibilities in accordance with the high standards expected of staff employed by the group. All staff will be made aware of this constitution, the commissioning strategy and the relevant internal management and control systems which relate to their field of work.
- 9.4. The group will maintain and publish policies and procedures (as appropriate) on the recruitment and remuneration of staff to ensure it can recruit, retain and develop staff of an appropriate calibre. The group will also maintain and publish policies, approved by the Remuneration Committee, on all aspects of human resources management, including grievance and disciplinary matters.
- 9.5. The group will ensure that its rules for recruitment and management of staff provide for the appointment and advancement on merit on the basis of equal opportunity for all applicants and staff.
- 9.6. The group will ensure that employees' behaviour reflects the values, aims and principles set out above.
- 9.7. The group will ensure that it complies with all aspects of employment law.
- 9.8. The group will ensure that its employees have access to such expert advice and training opportunities as they may require in order to exercise their responsibilities effectively.
- 9.9. The group will adopt a Code of Conduct for staff and will maintain and promote effective 'whistleblowing' procedures to ensure that concerned employees have means through which their concerns can be voiced. The group recognises and confirms that nothing in or referred to in this constitution (including in relation to the issue of any group press release, other public statement or disclosure) will prevent or inhibit the making of any protected disclosure (as defined in the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998) by any member of the group, any member of its governing body, any member of any of its committees or sub-committees or the committees or sub-committees of its governing body, or any employee of the group or of any of its members, nor will it affect the rights of any worker (as defined in that Act) under that Act.
- 9.10. Copies of this Code of Conduct, together with the other policies and procedures outlined in this chapter, will be available on the group's website at [www.wolverhamptonccg.nhs.uk](http://www.wolverhamptonccg.nhs.uk), available for inspection at the group's offices, and either by post or email, on request.

## **10. TRANSPARENCY, WAYS OF WORKING AND STANDING ORDERS**

## 10.1. General

- 10.1.1. The group will publish annually a commissioning plan and an annual report, presenting the group's annual report to a public meeting. This will be available on the group's website at [www.wolverhamptonccg.nhs.uk](http://www.wolverhamptonccg.nhs.uk), available for inspection at the group's offices, and either by post or email, on request
- 10.1.2. Key communications issued by the group, including the notices of procurements, public consultations, governing body meeting dates, times, venues, and certain papers will be published on the group's website at [www.wolverhamptonccg.nhs.uk](http://www.wolverhamptonccg.nhs.uk).
- 10.1.3. The group may use other means of communication, including circulating information by post, or making information available in venues or services accessible to the public.

## 10.2. Standing Orders etc

- 10.2.1. This constitution is also informed by a number of documents which provide further details on how the group will operate and which are deemed to be part of this constitution. They are the group's:
- a) *Standing Orders* (Appendix E), which set out the arrangements for meetings and the appointment processes to elect the group's representatives and appoint to the group's committees, governing body and its committees;
  - b) *Scheme of reservation and delegation* (Appendix F), which sets out those decisions that are reserved for the membership as a whole and those decisions that are the responsibilities of the group's governing body, the governing body's committees and sub-committees, the group's committees and sub-committees, individual members and employees;
  - c) *Prime financial policies* (Appendix G), which set out the arrangements for managing the group's financial affairs.

## APPENDIX A

### DEFINITIONS OF KEY DESCRIPTIONS USED IN THIS CONSTITUTION

<b>2006 Act</b>	National Health Service Act 2006
<b>2012 Act</b>	Health and Social Care Act 2012 (this Act amends the 2006 Act)
<b>Accountable Officer</b>	<p>an individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by the NHS Commissioning Board, with responsibility for ensuring the group complies with its obligations under:</p> <ul style="list-style-type: none"> <li>• sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act),</li> <li>• sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act),</li> <li>• paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and</li> <li>• any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Board for that purpose; and exercises its functions in a way which provides good value for money.</li> </ul>
<b>Area</b>	the geographical area that the group has responsibility for, as defined in Chapter 2 of this constitution
<b>Chair of the governing body</b>	the individual appointed by the group to act as chair of the governing body
<b>Chief Finance Officer</b>	the qualified accountant employed by the group with responsibility for financial strategy, financial management and financial governance
<b>Clinical Commissioning Group</b>	a body corporate established by the NHS Commissioning Board in accordance with Chapter A2 of Part 2 of the 2006 Act (as inserted by section 10 of the 2012 Act)
<b>Committee</b>	<p>a committee or sub-committee created and appointed by:</p> <ul style="list-style-type: none"> <li>• the membership of the group</li> <li>• a committee/sub-committee created/appointed by a committee created/appointed by the membership of the group</li> <li>• the governing body or one of its committees</li> </ul>
<b>Financial year</b>	this usually runs from 1 April to 31 March, but under paragraph 17 of Schedule 1A of the 2006 Act (inserted by Schedule 2 of the 2012 Act), it can for the purposes of audit and accounts run from when a clinical commissioning group is established until the following 31 March
<b>Group</b>	NHS Wolverhampton Clinical Commissioning Group, whose constitution this is
<b>Governing body</b>	<p>the body appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that a clinical commissioning group has made appropriate arrangements for ensuring that it complies with:</p> <ul style="list-style-type: none"> <li>• its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and</li> <li>• such generally accepted principles of good governance as are relevant to it.</li> </ul>
<b>Governing body member</b>	any member elected or appointed to the governing body of the group

<b>Healthcare professional</b>	A member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002
<b>Lay member</b>	a lay member of the governing body, appointed by the group. A lay member is an individual who is not a member of the group or a healthcare professional or as otherwise defined in regulations
<b>Member</b>	a provider of primary medical services to a registered patient list, who is a member of this group (see tables in Chapter 3 and Appendix B)
<b>Practice representatives</b>	an individual appointed by a practice (who is a member of the group) to act on its behalf in the dealings between it and the group, under regulations made under section 89 or 94 of the 2006 Act (as amended by section 28 of the 2012 Act) or directions under section 98A of the 2006 Act (as inserted by section 49 of the 2012 Act)
<b>Practice Groupings</b>	groups of practices who are working together to develop new community and primary care services in response to the Five Year Forward View. This includes the Primary Care Home, Vertical Integration and Medical Chambers groupings.
<b>Registers of interests</b>	registers a group is required to maintain and make publicly available under section 14O of the 2006 Act of the interests of: <ul style="list-style-type: none"> <li>• the members of the group;</li> <li>• the members of its governing body;</li> <li>• the members of its committees or sub-committees and committees or sub-committees of its governing body; and</li> <li>• its employees.</li> </ul>
<b>Regulations</b>	Any regulations issued by the Secretary of State under the 2006 Act, 2012 Act or any other relevant legislation that determine the duties, powers or conduct of a clinical commissioning group

## APPENDIX B - LIST OF MEMBER PRACTICES

Practice Name	Address
Dr S Agrawal Tudor Medical Practice	1 Tudor Road , Heath Town Wolverhampton, WV10 0LT
Dr S Asghar Caerleon Surgery	Dover Street Bilston Wolverhampton WV14 6AL
Dr D Bagary Low Hill Medical Centre	191 First Avenue, Low Hill Wolverhampton, WV10 9SX
Dr R Bilas & A Thomas	75 Griffiths Drive, Ashmore Park, Wednesfield, WV11 2JN
Dr D Bush Penn Surgery	2a Coalway Road, Penn Wolverhampton, WV3 7LR
Dr U Chelliah Showell Park	Fifth Avenue Wolverhampton WV10 9ST
Dr S Cowen & Partners The Surgery	119 Coalway Road, Penn Wolverhampton, WV3 7NA
Dr D DeRosa & Dr A Williams Warstones Health Centre	Pinfold Grove, Warstones Wolverhampton, WV4 4PS
Dr G Dhillon Ashfield Surgery	39 Ashfield Road, Fordhouses Wolverhampton, WV10 6QX
Dr J Fowler	470 Stafford Road Wolverhampton, WV10 6AR
Dr George & Partner Ashmore Park Health Centre	Griffiths Drive, Ashmore Park Wednesfield, WV11 2LH
Dr Hibbs & Partners Ettingshall Medical Centre	Herbert Street, Ettingshall Wolverhampton WV14 0NF
Dr Hibbs & Partners Parkfields Medical Practice	255 Parkfield Road, Parkfields Wolverhampton WV4 6EG
Intrahealth (Dr V Rai) Bilston Urban Village Medical Centre	Bankfield Road, Bilston Wolverhampton WV14 0EE
Intrahealth Pennfields Medical Centre	Upper Zoar Street, Pennfields Wolverhampton WV3 0JH
Dr Jackson & Partners Tettenhall Medical Practice	Lower Street Tettenhall Wolverhampton WV6 9LL
Dr J Kainth All Saints Surgery	17 Cartwright Street, All Saints Wolverhampton WV2 3BT
Dr M Kainth Primrose Lane Health Centre	Primrose Lane, Low Hill Wolverhampton WV10 8RN
Dr S Kanchan	1 Shale Street, Bilston Wolverhampton WV14 0HF
Dr M Kehler Keats Grove Surgery	7 Keats Grove, The Scotlands Wolverhampton WV10 8LY
Dr A Khan Duncan Street Primary Care Centre	Duncan Street, Blakenhall Wolverhampton WV2 3AN
Dr R Kharwadkar	68 Marsh Lane, Fordhouses Wolverhampton, WV10 6RU
Dr K Krishan Mayfields Medical Centre	272 Willenhall Road Wolverhampton, WV1 2GZ
Dr C Lal Bradley Medical Centre	83-84 Hall Green Street, Bradley Wolverhampton, WV14 8TH
Dr H Leung & Partner Lea Road Medical Practice	35 Lea Road, Pennfields Wolverhampton, WV3 0LS



<b>Practice Name</b>	<b>Address</b>
Dr Libberton	60 Cannock Road Wednesfield WV10 8PJ
Dr G Mahay Poplars Medical Practice	Third Avenue, Low Hill Wolverhampton WV10 9PG
Dr S Mittal Probert Road Surgery	Probert Road, Oxley Wolverhampton, WV10 6UF
Dr J Morgans & Partners	81 Prestwood Road West Wednesfield, WV11 1HT
Dr N Mudigonda Bilston Health Centre	Prouds Lane, Bilston Wolverhampton, WV14 6PW
Drs K Ahmed, V Pahwa & V Rai Bilston Health Centre	130a Park Street South, Goldthorn Hill Wolverhampton WV2 3JF
Dr J Parkes Alfred Squire Road Health Centre	Alfred Squire Road Wednesfield W11 1XU
Dr U Passi & Handa Leicester Street Medical Centre	Leicester Street, Whitmore Reans, Wolverhampton WV6 0PS
Dr G Pickavance & Partners The Newbridge Surgery	255 Tettenhall Road Wolverhampton WV6 0DE
Dr S Ravindran & Majid East Park Medical Centre	Jonesfield Crescent, East Park Wolverhampton WV1 2LW
Dr H Richardson & Partners Thornley Street Surgery	40 Thornley Street Wolverhampton WV1 1JP
Dr A Saini & Partner	62-64 Church Street, Bilston Wolverhampton WV14 0AX
Dr A Sharma & Partner Bilston Health Centre	Prouds Lane, Bilston Wolverhampton, WV14 6PW
Dr S Suryani The Surgery	Hill Street, Bradley, Wolverhampton WV148SB
Dr S Taylor & Cam	80 Tettenhall Road, Tettenhall Wolverhampton, WV1 4TF
Dr P Venkataramanan & Partner Grove Medical Centre	175 Steelhouse Lane Wolverhampton WV2 2AU
Dr Vij & Partners Whitmore Reans Health Centre	Low Street, Whitmore Reans Wolverhampton WV6 0QL
Dr Wagstaff & Partners Castlecroft Medical Practice,	Castlecroft Avenue Wolverhampton WV3 8JN
Dr White & Partners Penn Manor Medical Centre	Manor Road, Penn Wolverhampton WV4 5PY
Dr Whitehouse	199 Tettenhall Road Wolverhampton WV6 0DD

## APPENDIX C - NOLAN PRINCIPLES

1. The 'Nolan Principles' set out the ways in which holders of public office should behave in discharging their duties. The seven principles are:
  - a) **Selflessness** – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
  - b) **Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
  - c) **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
  - d) **Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
  - e) **Openness** – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
  - f) **Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
  - g) **Leadership** – Holders of public office should promote and support these principles by leadership and example.

Source: *The First Report of the Committee on Standards in Public Life* (1995)<sup>59</sup>

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<sup>60</sup> Available at <http://www.public-standards.gov.uk/>

## APPENDIX D – NHS CONSTITUTION

The NHS Constitution sets out seven key principles that guide the NHS in all it does:

1. **the NHS provides a comprehensive service, available to all** - irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population
2. **access to NHS services is based on clinical need, not an individual's ability to pay** - NHS services are free of charge, except in limited circumstances sanctioned by Parliament.
3. **the NHS aspires to the highest standards of excellence and professionalism** - in the provision of high-quality care that is safe, effective and focused on patient experience; in the planning and delivery of the clinical and other services it provides; in the people it employs and the education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population.
4. **NHS services must reflect the needs and preferences of patients, their families and their carers** - patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment.
5. **the NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population** - the NHS is an integrated system of organisations and services bound together by the principles and values now reflected in the Constitution. The NHS is committed to working jointly with local authorities and a wide range of other private, public and third sector organisations at national and local level to provide and deliver improvements in health and well-being
6. **the NHS is committed to providing best value for taxpayers' money and the most cost-effective, fair and sustainable use of finite resources** - public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves
7. **the NHS is accountable to the public, communities and patients that it serves** - the NHS is a national service funded through national taxation, and it is the Government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. The Government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose

Source: *The NHS Constitution: The NHS belongs to us all* (March 2012)<sup>60</sup>

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<sup>60</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_132961](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132961)

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**WOLVERHAMPTON CCG**
**Governing Body**  
**11 JULY 2017**
**Agenda item 9**

<b>TITLE OF REPORT:</b>	<b>Quarter 1 Board Assurance Framework, Position at end of Quarter 4 and Progress of Risk Register Refresh</b>
<b>AUTHOR(S) OF REPORT:</b>	Dawn Bowden, Quality Assurance Coordinator & Peter McKenzie, Corporate Operations Manager
<b>MANAGEMENT LEAD:</b>	Manjeet Garcha, Director of Nursing and Quality
<b>PURPOSE OF REPORT:</b>	To outline the continued progress in the development of the Board Assurance Framework (BAF) at Quarter 1 and to present the refreshed Corporate Risk Register for the Governing Body's consideration
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This Report is intended for the public domain. Any confidential information relating to any risks has been redacted.
<b>KEY POINTS:</b>	<ul style="list-style-type: none"> <li>• Following an internal audit of the CCG's Risk Management arrangements, an action plan has been developed to improve the organisations' approach to managing risk.</li> <li>• The Governing Body has agreed clear strategic objectives and risks are being mapped against these to provide assurance to the Governing Body that strategic risks are being effectively managed.</li> <li>• A thorough review of the organisation's risk profile has taken place to identify Corporate/ organisational risks for Governing Body consideration.</li> </ul>
<b>RECOMMENDATION:</b>	That the Governing Body <ul style="list-style-type: none"> <li>• Notes progress with the Risk Register and Board Assurance Framework</li> <li>• Notes movement/progression of high level risks</li> <li>• Endorses the next steps of the Action Plan</li> </ul>
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	This report details progress with developing the overall Board Assurance Framework and is therefore relevant to all of the aims and 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	

## 1. BACKGROUND AND CURRENT SITUATION

- 1.1. The Board Assurance Framework BAF and Risk Register were refreshed following an audit by Price Waterhouse Cooper in November/December 2016.
- 1.2 As part of this work, strategic objectives were updated at the Governing Body development session in March 2017. Risks to the organisation and the overall BAF are now aligned to these objectives, which are set out at **Appendix 1**.

## 2. QUARTER 1 UPDATE

- 2.1. The Risk Register remains a ‘live’ system, and continues to be monitored and managed by executives and risk owners in line with the Risk Management Strategy. This is an ongoing process and there is still work to do to ensure that the CCG is capturing and effectively managing risk across its portfolio of operations.
- 2.2. The Corporate Operations Manager has been tasked with reviewing the risk register to ensure that ‘Corporate’ risks for the Governing Body to consider and own (those which are relevant to the BAF) are identified. This exercise involved assessing the scope of risks to determine whether those risks captured on the risk register were risks to the organisation achieving overall objectives or risks to the delivery of individual programmes of work.
- 2.3. 62 risks on the CCG’s Datix system were reviewed and eight were initially identified as ‘Corporate Risks’. The remaining programme level risks have been assessed to identify themes, from which a further four composite corporate risks have been identified. These risks are summarised in **Appendix 2**.

- 2.4. As part of the response to the internal audit report on risk management arrangements, the CCG has revised the structure of the BAF. Previously, the BAF was aligned to the four domains set out by NHSE in April 2016 as part of their Improvement and Assessment Framework for CCGs. The new structure, based on the Corporate objectives agreed by the Governing Body allows risks to be aligned to and an assessment made of the likelihood of objectives not being met.
- 2.5. The review of the Risk Register has allowed both the corporate level risks and identified programme risks to be aligned against the BAF. This is set out at **Appendix 3**. The review has identified that a number of existing risks have yet to be aligned to the BAF objectives and thus there are gaps in the overall risk profile of the BAF. This means that a full assessment of the risk to objectives being achieved and the adequacy of controls in place is still difficult to achieve.
- 2.6. The CCG's Senior Management Team are actively working to ensure that all risks on the Datix system are aligned against the agreed corporate objectives through on-going reviews. They are also conducting an exercise to support the Governing Body in assessing the overall risk to individual objectives being achieved to ensure that a fully populated BAF is available for the next Governing Body review.

### **3. INTERNAL AUDIT ACTION PLAN - UPDATE**

- 3.1. The Governing Body has previously received updates on the action plan developed to address the other issues identified in the Internal Audit report into risk management. In particular the issues to address lack of risk ownership and to provide evidence of scrutiny throughout the risk management process.
- 3.2. Work continues to ensure that effective and appropriate reports are available to support the process, including the development of summary dashboard information. Discussions continue with the supplier to determine whether the Datix system is able to support this process, either through the existing configuration or with additional functionality.
- 3.3. As highlighted above, the Senior Management Team continue to actively work to ensure risks are captured and reviewed at the appropriate level within the organisation, including those assigned to Governing Body committees. Risks within the system has been allocated to committees and there has been some discussion during the most recent cycle of meetings. Once the work outlined above has been completed, it will be possible for the committees to have a complete overview of

their risk profile and to effectively take ownership of managing the risks allocated to them.

- 3.4. This will inevitably be an iterative process as committees (and programme boards where appropriate) review risks and assess whether they can and should be escalated or de escalated. Work continues to ensure terms of reference for committees reflect the new arrangements, that Chairs are aware of their responsibilities and that clear records are kept to highlight the scrutiny of arrangements. The Audit and Governance Committee will play a key role in assuring the Governing Body that appropriate levels of scrutiny are being applied as arrangements are embedded.
- 3.5. The CCG's Risk Management Strategy is currently being revised and will be considered by the Quality and Safety Committee in due course. The updated strategy will be supported by further staff training which will aim to ensure the principles of risk management are effectively embedded throughout the organisation.

#### **4. RISK POSITION – SUMMARY**

- 4.1. In light of the detail above, the Governing Body will recognise that the risk position for the CCG remains a work in progress. As has previously been reported, the quantification system used in Datix has been aligned to new guidance from the National Patient Safety Agency using the new scoring system in table 1 below.
- 4.2. The new system was reviewed by Executives in February 2017 and a series of staff briefings took place in March and April 2017 for risk managers and handlers to ensure that they were aware of the revised scoring arrangements.



Old...

Likelihood of recurrence	Consequence				
	Negligible	Minor	Moderate	Major	Catastrophic
Almost certain: (Will undoubtedly happen/recur, possibly frequently)	●	●	●	●	●
Likely: Will probably happen/recur, but it is not a persisting issue	●	●	●	●	●
Possible: Might happen or recur occasionally	●	●	●	●	●
Unlikely: Do not expect this to happen/recur, but it is possible it may do	●	●	●	●	●
Rare: This will probably never happen/occur	●	●	●	●	●

New has 4 tiers, as per below bottom left. Moderate now covers most 'high green risks'

New...

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Likelihood (initial)	Consequence (initial)				
	Negligible	Minor	Moderate	Major	Catastrophic
Almost certain: (Will undoubtedly happen/recur, possibly frequently)	●	●	●	●	●
Likely: Will probably happen/recur, but it is not a persisting issue	●	●	●	●	●
Possible: Might happen or recur occasionally	●	●	●	●	●
Unlikely: Do not expect this to happen/recur, but it is possible it may do	●	●	●	●	●
Rare: This will probably never happen/occur	●	●	●	●	●

Table 1 – Risk Quantification matrix

- 4.2 As a result of the on-going work including an executive led risk cleanse, there has been a significant reduction in the number of risks on the Risk Register. At the end of Quarter 3 there were 121 open risks, this reduced to 79 at the end of Quarter 4 and now stands at 61 open risks on the risk register at the end of Quarter 1 2017/18.
- 4.3 There were 4 risks rated “Red/Extreme” as of 26<sup>th</sup> June 2017. Details of these risks can be found in Appendices 2 & 3.

Number of Risk Register Entries	End of Q4, 16/17	End of Q1, 17/18
Open Risks	79	61
Extreme	6	4
High	41	31
Moderate	30	26
Low	2	0

## 5. CLINICAL VIEW

- 5.1. A clinical view has not been sought for the purpose of this report; however, if relevant, a clinical view is always sought via the appropriate committee membership.



## 6. PATIENT AND PUBLIC VIEW

6.1. Not applicable for the purpose of this report.

## 7. KEY RISKS AND MITIGATIONS

7.1. The CCG BAF and Risk Register on-going refresh work is critical, as failure to identify and manage risks is a risk to the achievement of the CCG's strategic objectives.

## 8. IMPACT ASSESSMENT

### *Financial and Resource Implications*

8.1. There is still some on-going work to be carried out to address the risks identified in the review. The executive ownership of this portfolio sits with the Chief Nurse and the administrative tasks are split between 2 x Band 6 Quality Assurance Officers. Their remit includes Datix administration and report compilation. Priority has been given to this work which has resulted in other work streams being delayed and further compounded by staff changes; however, this is being monitored by the Head of Quality and Risk

### *Quality and Safety Implications*

8.2. Quality is at the heart of all CCG work and whilst no impact assessment has been undertaken for the purpose of this report, all risks have a patient safety and quality impact assessment

### *Equality Implications*

8.3. There are no Equality Implications associated with this report.

### *Legal and Policy Implications*

8.4. As highlighted above, the Risk Management Strategy is being updated to reflect the emerging arrangements.

### *Other Implications*

8.5. There are no other implications arising from this report

<b>Name</b>	<b>Dawn Bowden</b>	<b>Peter McKenzie</b>
<b>Job Title</b>	<b>Quality Assurance Coordinator</b>	<b>Corporate Operations Manager</b>
<b>Date:</b>	<b>June 2017</b>	

**ATTACHED:**

- Appendix 1 Strategic Objectives/Aims
- Appendix 2 Corporate Risk Register
- Appendix 3 Board Assurance Framework Risk Mapping

**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.**

	<b>Details/ Name</b>	<b>Date</b>
Clinical View	<b>Not Applicable</b>	
Public/ Patient View	<b>Not Applicable</b>	
Finance Implications discussed with Finance Team	<b>Not Applicable</b>	
Quality Implications discussed with Quality and Risk Team	<b>M Garcha</b>	<b>June 2017</b>
Equality Implications discussed with CSU Equality and Inclusion Service	<b>Not Applicable</b>	
Information Governance implications discussed with IG Support Officer	<b>Not Applicable</b>	
Legal/ Policy implications discussed with Corporate Operations Manager	<b>Peter McKenzie</b>	<b>June 2017</b>
Other Implications (Medicines management, estates, HR, IM&T etc.)	<b>Not Applicable</b>	
Any relevant data requirements discussed with CSU Business Intelligence	<b>Not Applicable</b>	
<b>Signed off by Report Owner (Must be completed)</b>		



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## Wolverhampton Clinical Commissioning Group - Strategic Aims and Objectives 2017/2019

Strategic Aims	Strategic Objectives
1. Improving the quality and safety of the services we commission	1a. Ensure on-going safety and performance in the system
2. Reducing health inequalities in Wolverhampton	2a. Improve and develop Primary Care in Wolverhampton 2b. Deliver new models of care that support care closer to home and improve management of Long Term Conditions.
3. System effectiveness delivered within the CCG's financial envelope	3a. Proactively drive our contribution to the Black Country STP 3b. Greater integration of health and social care services across Wolverhampton 3c. Continue to meet our Statutory Duties and responsibilities 3d. Deliver improvements in the infrastructure for health and care across Wolverhampton

Strategic Objectives expanded:

- 1a. Continually 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.
- 2a. 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.
- 2b. 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.
- 3a. 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.
- 3b. 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".
- 3c. 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.
- 3d. 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.

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## Corporate - Organisational Risks

New ID	Relevant Datix ID	Title and Summary	Opened	PM Review - Objective	Responsible Committee	Handler	Manager	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level
CR01	434	<b>Failure to meet QIPP Targets</b> QIPP Delivery is vital to ensuring that the CCG meets its financial targets. Challenging QIPP targets (including a £2m unallocated QIPP position at the beginning of year) puts the delivery of the CCG's financial targets at risk	12/08/2016	3c - Meeting our Statutory Duties (Delivery of Financial duties)	Finance and Performance	Sawrey, Lesley - Deputy CFO.	Sawrey, Lesley - Deputy CFO.	12	High	6	Moderate
CR02	290	<b>Cyber Attacks</b> Cyber attacks on the IT network infrastructure could potentially lead to the loss of confidential data into the public domain if relevant security measures are not in place. There is also serious clinical/financial and operational risks should there be a major failure leaving the organisation unable to function normally. In such an instance, Business Continuity Plans would need to be enacted.	31/01/2014	1a - Monitoring ongoing safety and performance in the system	Executives	Bahia, Gus - CCG Business Operations Manager	Hastings, Mike - CCG Director of Business and Performance	4	Moderate	4	Moderate
CR03	475	<b>NHS Constitutional Targets</b> There is a risk that ongoing pressure in the system will lead to Providers missing statutory NHS Constitutional targets with the associated impact on patient outcomes	28/02/2017	1a - Monitoring ongoing safety and performance in the system	Finance and Performance	Bahia, Gus - CCG Business Operations Manager	Bahia, Gus - CCG Business Operations Manager	8	High	8	High
CR04	469 - Full Delegation Capacity 268 - Loss of Key Finance Staff 337 - Full Delegation 478 - GMS Contract Changes	<b>CCG Staff Capacity for deliver new Commissioning Responsibilities</b> The CCG has taken on greater responsibility for commissioning Primary Care from NHS England. The additional work this requires is being met within existing resources which creates risks for delivery of this (and other) programmes of work	31/01/2017	3c - Meeting our Statutory Duties (Delivery of commissioning responsibilities - delegated)	Executives	Middlemiss, Vic - Head of Contracting and Procurement	Middlemiss, Vic - Head of Contracting and Procurement	9	High	9	High

## Corporate - Organisational Risks

New ID	Relevant Datix ID	Title and Summary	Opened	PM Review - Objective	Responsible Committee	Handler	Manager	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level
CR05	312	<b>Mass Casualty Planning</b> There is a risk that effective plans will not be in place for CCG and other agencies will not be in place	01/05/2014	3c - Continue to meet statutory duties and responsibilities (Emergency Planning)	Quality and Safety	Kalea, Tally - Commissioning Operations Manager	Hastings, Mike - CCG Director of Business and Performance	6	Moderate	8	High
CR06	466 453 - Data Sharing 147 - Provider issues 472 - Procuring a Step in Provider 473 - Repeat Dressings	<b>Vocare</b> Ongoing issues with the provider mean that there are concerns about the overall safety and sustainability of the service	30/01/2017	1a - Monitoring ongoing safety and performance in the system	Quality and Safety	Forsyth, Steven - Head of Quality and Risk	Garcha, Manjeet - CCG Executive Lead for Nursing and Quality	16	Extreme	16	Extreme
CR07	428 262 - CHC Budget	Failure to meet overall financial targets Challenging financial targets mean that there is a risk that the CCG will not meet it's overall financial target.	14/06/2016	3c Meeting our statutory duties (Meeting Financial duties)	Finance and Performance	Sawrey, Lesley - Deputy CFO.	Sawrey, Lesley - Deputy CFO.	12	High	6	Moderate
CR08	495	<b>New Ways of Working across the STP</b> The STP is complex and works across both providers commissioners and local authorities. This requires building new relationships and overcoming organisational barriers . Management capacity to fulfil new roles will be a risk to the CCG as well as the move to new ways of working with partners in a complex system	21/06/2017	3a - Proactively drive the CCG's Contribution to the Black Country STP	Governing Body	Dr Helen Hibbs - Accountable Officer	Dr Helen Hibbs - Accountable Officer	16	Extreme		Extreme
CR09	489 - Safeguarding Midwife 479 - LAC Health Checks 476 - Named Dr for LAC 321 - Provider DBS Check renewals	<b>Safeguarding Compliance</b> There are a number of interlinked issues with the delivery of safeguarding responsibilities across the system that create a risk that the CCG's statutory Duties will not be met		1a - Monitoring ongoing safety and performance in the system	Quality and Safety	Lorraine Millard	Garcha, Manjeet - CCG Executive Lead for Nursing and Quality	12	High	12	High



## Corporate - Organisational Risks

New ID	Relevant Datix ID	Title and Summary	Opened	PM Review - Objective	Responsible Committee	Handler	Manager	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level
CR10	415 - BCF Finance 450 - BCF Capacity 454 - Community Equipment 425, 451 - Community Neighbourhood Teams 407 - Discharge to Assess (DTC) 445 - Fibonnacci 480 - HARP Service 471 - Risk Stratification	<b>BCF Programme</b> The Better Care Fund Programme is an ambitious programme of work based on developing much closer integration between NHS and Local Authority Social Care services. There are significant risks associated with the programme not meeting its targets both financially and for patient outcomes		3b - Greater Integration of health and Social Care Services across Wolverhampton	Commissioning Committee	Andrea Smith	Marshall Steven	12	High	12	High
CR11	487 - Cost of new roles in Primary Care 485 - Nurse Training Roles 486 - GP Retirements 440 - Clinical Pharmacist role 459 - Student Placements	<b>Primary Care Strategy - Workforce Issues</b> There are a number of issues associated with workforce in Primary Care that may create a risk to the delivery of the objectives of the strategy in creating a multiskilled workforce able to deliver care closer to home		2a - Improve and develop Primary Care in Wolverhampton	Governing Body	Sarah Southall	Marshall Steven	12	High	12	High
CR12	223 - MCP Contractual Governance 467 - MCP New way of Working 468 - Group Capacity 477 - VAT implications	<b>New Ways of Working in Primary Care</b> There are a number of issues with the developing new approach to working. This potentially puts at risk the benefits for patients and the prospect of system change		2a - Improve and develop Primary Care in Wolverhampton	Primary Care Commissioning Committee	Steven Marshall	Marshall Steven	12	High	12	High

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BAF Objectives	Relevant Corporate Risks	Current Score	Relevant Programme Risks	Current Score
<b>1. Improving the quality and safety of the services we commission</b>				
a. <u>Ensure on-going safety and performance in the system</u> 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	CR02 - Cyber Attacks	4	474 - CHIS System	15
	CR03 - NHS Constitutional Targets	8	471 - Risk Stratification	6
	CR06 - Vocare	16	484 - Patient Choice	15
	CR09 - Safeguarding Compliance	12	425 - Community Neighbourhood Teams	12
			480 - HARP service	9
			379 - MSK Procurement	8
			479 - LAC health Assessments	4
<b>2.Reducing health inequalities in Wolverhampton</b>				
a. <u>Improve and develop primary care in Wolverhampton</u> – 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	CR11 - Primary Care Strategy Workforce Issues	12	487 - New Roles in Primary Care	12
	CR12 - New Ways of Working in Primary Care	12	412 - CHIS	6
			485 - Placement Withdrawals	9
			471 - Risk Stratification	6
			462 - Locality Working	12
			484 - Patient Choice	15
			409 - Care Home Team	9
			459 - Student Placements	8
			465 - Violent Patient Scheme	12
			440 - Clinical Pharmacists	9
		477 - VAT for New Care Models	9	
b. <u>Deliver new models of care that support care closer to home and improve management of Long Term Conditions</u> 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	CR12 - New Ways of Working in Primary Care	12	471 - Risk Stratification	6
			462 - Locality Working	12
			478 - GMS Contract Changes	6
			488 - Extended Hours	9
			477 - VAT for new care models	9
			379 - MSK Procurement	8
<b>3. System effectiveness delivered within our financial envelope</b>				
a. <u>Proactively drive our contribution to the Black Country STP</u> 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	CR08 - New Ways of Working across the STP		415 - BCF Finance	16
b. <u>Greater integration of health and social care services across Wolverhampton</u> 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.'	CR10 - BCF Programme	12	462 - Locality Working	12
			484 - Patient Choice	15
c. <u>Continue to meet our Statutory Duties and responsibilities</u> 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	CR01 - Failure to meet QIPP Targets	6	301 - Property Services Recharge	10
	CR04 - Capacity to deliver new Commissioning Responsibilities	9	484 - Patient Choice	15
	CR05 - Mass Casulty Planning	6	136 - Health and Safety	8
	CR07 - Failure to meet overall Financial Targets	6	357 - Co-Commissioning Responsibilities	4
			274 - Conflicts of Interest	12
			329 - CSU Contracting	9
		429 - Specialised Commissioning	12	

BAF Objectives	Relevant Corporate Risks	Current Score	Relevant Programme Risks	Current Score
<p>d. Deliver improvements in the infrastructure for health and care across Wolverhampton</p> <p>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.</p>			489 - Named Midwife	9
			480 - HARP Service	9
			445 - Fibonacci	12
			471 - Risk Stratification	6
			132 - IM&T Programme	6

**WOLVERHAMPTON CCG**
**Governing Body**  
**11<sup>th</sup> July 2017**
**Agenda item 10**

<b>TITLE OF REPORT:</b>	Better Care Fund Programme 2017-2019 Plan
<b>AUTHOR(s) OF REPORT:</b>	Andrea Smith
<b>MANAGEMENT LEAD:</b>	Steven Marshall
<b>PURPOSE OF REPORT:</b>	<ul style="list-style-type: none"> <li>To provide Governing Body of a summary of work undertaken and achievements for 2016/17</li> <li>To provide assurance of the development of the BCF 2017-19 Draft plan, including Pooled budget which has input from Director of Finance and the Director of Strategy and Transformation.</li> <li>To seek approval for delegated sign off of the plan including Pooled Budget to Helen Hibbs (Accountable Officer) and Tony Gallagher (Director of Finance).</li> </ul>
<b>ACTION REQUIRED:</b>	<input checked="" type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	Public
<b>KEY POINTS:</b>	<ul style="list-style-type: none"> <li>Short bullet points</li> <li>Ideally no more than three</li> <li>That give an overview of the main issues in the report</li> </ul>
<b>RECOMMENDATION:</b>	<p>The report recommends that the Governing Body approve the Draft BCF 2017-19 in its current form, acknowledging that there may be required changes following the publication of the national planning guidance.</p> <p>The reports seeks assurance to continue to develop the pooled budget, with already agreed delegated approval, the final version of which will be presented to the Governing Body</p>
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	[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	Within the BCF programme we continually aim to improve the quality and safety of the services we commission by reviewing current pathways and processes and developing integrated health and social care pathways where this will improve both

	the quality and the patient experience.
2. Reducing Health Inequalities in Wolverhampton	The BCF programme strives to ensure that health inequalities are reduced across the City. The plan is based on data and evidence which allows us to understand the health inequalities that we are aiming to address
3. System effectiveness delivered within our financial envelope	The Better Care fund programme is supported by a pooled budget with the City of Wolverhampton Council. The pooling of resources gives us the opportunity to use our resources more effectively together

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

## **1. BACKGROUND AND CURRENT SITUATION**

- 1.1. This report is aimed at providing the Governing Body an overview of delivery and achievements for 2016/17 and to provide an update on the development of the BCF plan for 2017-19.
- 1.2. This report also seeks to confirm delegation for approval of the BCF plan for 2017-19, including the Pooled budget arrangements to Helen Hibbs (Accountable Officer) and Tony Gallagher (Director of Finance).

## **2. Delivery of BCF Programme 2016/7 - Metrics**

### *2.1. Delayed Transfers Of Care*

2.1.1 Performance has improved significantly from the 2015-16 baseline with 2,656 fewer delayed days, which represents a reduction of 18%. However, this falls short of the target of 6,430 fewer days, a reduction of 57%. This has been affected by several long term delayed patients from Mental Health settings & the increased proportion of delays caused by people waiting for a package of care in their own home, nursing home care or a residential placement.

2.1.2 The establishment of the Discharge to Assess project (D2A) to develop and implement an integrated D2A pathway is in place to improve performance in 2017-18.

### *2.2. Non – Elective Admissions*

2.2.1 SUS data shows us that there has been a reduction of 1600 emergency admissions into RWT, of which 585 of the most complex and typically highest cost cases are directly attributed to BCF schemes.



2.2.2 It is however extremely difficult to prove what didn't happen (patients weren't admitted) and therefore we asked the RITs to undertake an audit of their activity. The audit was undertaken for Q4 2016/17 and the audit results are shown in the table below.

Count of Diagnosis Code	Month							Total Seen	Total admitted
	Jan 17	Admitted	Feb 17	Admitted	Mar 17	Admitted	Admitted		
Acute Bronchiolitus	5	1	10		14		29	1	
Acute Lower Respiratory Infection	56	3	25	1	26	4	107	8	
Acute Upper Respiratory Infection	6		4		1		11	0	
Asthma	1		3	2			4	2	
Bronco Pneumonia	5	2	2	1			7	3	
CCF	1		2		4	2	7	2	
Cellulitis	25	1	31	1	21	1	77	3	
Complication of Catheter	3		3	1	3		9	1	
Constipation	2		1	1	3		6	1	
COPD	4		4		5		13	0	
COPD - Infective Exacerbation	5	2	2		7	1	14	3	
COPD - Non Infective Exacerbation	4				2		6	0	
Dyspepsia	1						1	0	
Gastritis	5	1	1		2		8	1	
Hypoglocaemia	1						1	0	
Lobar Pneumonia	9	2			5		14	2	
Localised Oedema	4	1	4	1	7		15	2	
Malaise and Fatigue	20	2	14	1	30		64	3	
Nausea and Vomiting	7	1	1		1		9	1	
Pneumonia	1						1	0	
Septicimia	3	3	4	3	1	1	8	7	
Ulcer of Lower Limb	3		2		1		6	0	
UTI	43	1	33	1	37	1	113	3	
Vascular Dementia	4		5	1	2		11	1	
Viral Infection	50		19		34		103	0	
other	24	7	21	5	31	8	76	20	
Essential Hypertension			4		1		5	0	
LVF			3	2	3	1	6	3	
Chest Pain			3	1			3	1	
Generalised Iodopathic Epilepsy					1	1	1	1	
<b>Grand Total</b>	<b>292</b>	<b>27</b>	<b>201</b>	<b>22</b>	<b>242</b>	<b>20</b>	<b>735</b>	<b>69</b>	
								<b>9.39%</b>	

2.2.3 This shows that the admission avoidance rate is approximately 90%. If those patients who were seen and avoided (666) had been admitted this equates to a potential saving of £1.3m for the quarter (based on estimated £2k per emergency admission).



### 2.3 *Permanent Admissions to residential and care homes*

- 2.3.1 Admissions have increased to 385 in the year against a target of 252. Admissions per month have been significantly higher than previous years. There was an average of 32 admissions each month in 2016-17 compared with 25 per month in 2015-16.
- 2.3.2 Numbers of admissions rose throughout 2016-17 and remained high in the first six months of 2016-17. The number of admissions each month has started to fall in the second half of the year, however, admissions remain higher than the same period in the previous year. The number of people admitted to permanent nursing care in the year has increased 45% from 93 to 135, whereas the number of people admitted to permanent residential care has increased by just 19% from 210 to 250. In total the proportion of admissions to nursing care has increased from 31% to 35% suggesting that those that are admitted to permanent care have higher care needs.

### 2.4 *Effectiveness of Reablement*

- 2.4.1 In 2016-17 the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services was 74.5% against a target of 80.3%. This is a slight reduction on the 2015-16 result of 75.6%. However, there has also been a significant reduction in the cohort that received reablement following discharge from hospital due to the ending of the joint funding agreement of the Community Intermediate Care Team which means that fewer people received reablement following a joint assessment.
- 2.4.2 Although there has been no increase in the proportion of older people who remain at home 91 days after discharge into reablement, the proportion of adults who have received a short term social care intervention designed to maximise independence who do not go on to need long term support has increased from 80.7% to 84.2% demonstrating that in Wolverhampton, earlier diagnosis, intervention and reablement is working to ensure that people and their carers are less dependent on intensive services.

### 2.5 *Programme achievements*

Whilst the performance against national targets has not been fully achieved the programme has delivered a number of successful projects throughout the year, some of which are outlined below:-

- Rapid Intervention Team (RITs) – Now operating as a seven day admission avoidance service and is accepting referrals from West Midlands Ambulance Service.
- Risk Stratification – Community Matrons working with General Practitioners (GPs) to identify persons of high risk of admission and proactively manage their care. Work is continuing to continue this proactive approach.



- Integrated Health and Social Care Multi-Disciplinary Team (MDT) working – three Locality based MDTs, meeting on a monthly basis to discuss an identified caseload of people with complex needs.
- Wound Care Pathway – Development of a multiagency Wound Care Pathway.
- End of Life Pathway – Development of a multiagency End of Life Care pathway.
- Mental Health – Development of Street Triage and a prevention focused service called ‘Starfish’.
- Discharge to Assess (D2A) – Establishment of a D2A project to develop and implement an Integrated D2A pathway.
- Memory Matters – Establishment and rollout of Advice and Information clinics across the city for people who are concerned about memory issues and possible dementia delivered from non-health buildings.
- Dementia - A business case was agreed by the Accident & Emergency (A&E) Board to ‘pump prime’ service transformation by increasing the number of dedicated liaison and outreach dementia staff across Royal Wolverhampton Trust (RWT) and by increasing the remit of their role to pro-actively assess and navigate the required next steps for patients with dementia or suspected dementia presenting in RWT.
- Social Prescribing – Partnership working with Wolverhampton Voluntary Sector Council (WVSC) to deliver a 12 month Social Prescribing pilot.
- Wolverhampton Information Network (WIN) – Enhancement of the WIN to create a single information portal for health, social care, voluntary and community services.
- Data Sharing Agreement – City wide data sharing agreement approved to enable Integrated teams to work more effectively.
- Fibonacci – The implementation of an IT system allowing MDT members to view health and social care data.
- Link made with Housing services to enhance the relationship between hospital avoidance and discharge with housing needs.

### 3. BCF plan 2017 – 19

- 3.1 The publication of National Planning Guidance is further delayed. It is anticipated guidance will follow the General Election and subsequent Queen’s speech. Submission dates have not been published and are expected within the guidance. We have, however, had sight of draft guidance and therefore the plan is being developed in line with this, in anticipation of a short turnaround time for submission following publication.

3.2 The new submission will be a two-year plan covering period 2017-19. The number of National Conditions has been reduced from 8 to 4, these being:-

- A jointly agreed plan
- National Health Service (NHS) contribution to social care is maintained in line with inflation
- Agreement to invest in NHS-commissioned out-of-hospital services
- Implementation of the High Impact Change Model for managing Delayed Transfers of Care (DToC)

Whilst we will not be measured on the remaining conditions from last year we are expected to still evidence how we are addressing them. These are:-

- Delivery of 7 day services
- Better data sharing between health and social care
- Joint approach to assessments
- Agreement on the consequential impact of the changes upon Providers

3.3 The National Performance Metrics remain the same as previous years:-

- DToC
- Reduction of Non-elective admissions
- Admissions to residential and care homes
- Effectiveness of reablement

3.4 The Pooled budget is under development. Regular meetings are being held between SRO's (Steven Marshall, Claire Skidmore, and David Watts (CWC)) and finance colleagues from both CCG and CWC. The latest iteration of the pooled budget stands at £67.1m with a 56% (CCG) and 44% (CWC) split of financial input. This includes the improved Better Care Fund (iBCF) and the additional Adults Social Care monies announced in the Spring budget of which totals £7.6 million. It should be noted that the fund includes £6.5 million representing the NHS transfer to Social Care (S256). In addition to the revenue budget the fund includes a capital grant of £2.7 million (Disabled Facilities Grant).

Once finalised, the Section 75 agreement will be developed and the pooled budget will be presented back to Governing Body.

3.5 Improved Better Care Fund (iBCF)

3.5.1 Additional funding (iBCF) was announced in the Spring budget. This additional funding was given to Councils to allocate to 3 areas.

- Ensuring local social care provider market is supported
- Meeting adult social care needs
- Reducing pressures on NHS /managing transfers of care

- 3.5.2 Department of Communities & Local Government (DCLG) wrote to Chief Executives on 26 May 2017 to set out the information they will require quarterly and when they expect to receive it.
- 3.5.3 Currently CWC have allocated approximately 29% of their funding to reducing pressures on the NHS. A list of projects has been developed and agreed at Cabinet however further work is required on the detail on delivery. The guidance states plans will be jointly agreed with Wolverhampton Clinical Commissioning Group (CCG) and that A&E delivery boards will have oversight.

#### **4. CLINICAL VIEW**

- 4.1. The draft plan has been circulated for comment and input CCG clinical reference group, BCF Programme Board, RWT, BCPFT

#### **5. PATIENT AND PUBLIC VIEW**

- 5.1. The draft plan has been circulated for comment and input to Healthwatch and to Wolverhampton Voluntary Sector Council

#### **6. KEY RISKS AND MITIGATIONS**

- 6.1. There is a risk that there will be extremely tight deadlines for submission of the plan, but there is a well-developed draft that will only require review and subtle amendments in order to submit.
- 6.2. A key risk is the content of the Pooled budget (section 75 agreements) in particular the amount of resource that the each party will put into the pool, and the level of risk that the each party will under write as a result of over / under performance

#### **7. IMPACT ASSESSMENT**

##### ***Financial and Resource Implications***

- 7.1. The Pooled budget is currently under development and once finalised a new Section 75 agreement will be produced.

##### ***Quality and Safety Implications***

- 7.2. Quality and Safety implications are identified on a project by project basis. Quality Impact Assessments are completed for each project.

##### ***Equality Implications***



7.3. Equality implications are identified on a project by project basis. Quality Impact Assessments are completed for each project.

**Legal and Policy Implications**

7.4. Legal advice will be sought in the development of the Section 75 agreement and Information Governance leads are involved in the programme to ensure that relevant policies are adhered to.

**Other Implications**

7.5. N/A

**Name: Andrea Smith**  
**Job Title: Head of Integrated Commissioning**  
**Date: 28<sup>th</sup> June 2017**

**ATTACHED:**

DRAFT BCF Plan V.10

**RELEVANT BACKGROUND PAPERS**

Integration and Better Care Fund Policy Framework 2017-19  
High Impact Change Model, Managing Transfers of Care  
The Improved Better Care Fund Grant Determination 2017-18

**REPORT SIGN-OFF CHECKLIST**

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

	<b>Details/ Name</b>	<b>Date</b>
Clinical View	<b>CRG</b>	<b>April 2017</b>
Public/ Patient View	<b>Health watch</b>	<b>April 2017</b>
Finance Implications discussed with Finance Team	<b>Lesley Sawrey/Claire Skidmore</b>	<b>Ongoing throughout development of Pooled budget. January 2017 - present</b>
Quality Implications discussed with Quality and Risk Team	<b>Steven Forsyth</b>	



Equality Implications discussed with CSU Equality and Inclusion Service	<b>Juliet Herbert</b>	
Information Governance implications discussed with IG Support Officer	<b>Applicable for individual projects</b>	
Legal/ Policy implications discussed with Corporate Operations Manager	<b>Peter McKenzie</b>	
Other Implications (Medicines management, estates, HR, IM&T etc.)	<b>Mike Hastings (estates)</b>	
Any relevant data requirements discussed with CSU Business Intelligence		
<b>Signed off by Report Owner (Must be completed)</b>	<b>Andrea Smith</b>	<b>28<sup>th</sup> June 2017</b>



## 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	<p>a. <u>Ensure on-going safety and performance in the system</u> 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</p>
2. Reducing health inequalities in Wolverhampton	<p>a. <u>Improve and develop primary care in Wolverhampton</u> – 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</p> <p>b. <u>Deliver new models of care that support care closer to home and improve management of Long Term Conditions</u> 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</p>
3. System effectiveness delivered within our financial envelope	<p>a. <u>Proactively drive our contribution to the Black Country STP</u> 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.</p> <p>b. <u>Greater integration of health and social care services across Wolverhampton</u> 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.’</p> <p>c. <u>Continue to meet our Statutory Duties and responsibilities</u> 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</p> <p>d. <u>Deliver improvements in the infrastructure for health and care across Wolverhampton</u> 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.</p>



## Wolverhampton Health and Care Economy BCF

### Narrative Plan 2017-2019

(DRAFT)



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## 1. Approval and Sign-Off

### 1.1 Summary of Plan

<b>Local Authority</b>	City of Wolverhampton Council
<b>CCG</b>	Wolverhampton CCG
<b>Boundary Differences</b>	None
<b>Date submitted first draft</b>	
<b>Date submitted final plan</b>	
<b>Minimum required value of Pooled Budget</b>	
<b>Total agreed value of Pooled Budget</b>	

### 1.2 Approval and signatures

<b>Signed on behalf of City of Wolverhampton Council</b>	
<b>by</b>	Linda Sanders
<b>Position</b>	Strategic Director
<b>Date</b>	
<b>Signed on behalf of Wolverhampton CCG</b>	
<b>by</b>	Dr Helen Hibbs
<b>Position</b>	Accountable Officer
<b>Date</b>	
<b>Signed on behalf of Royal Wolverhampton Trust</b>	
<b>By</b>	David Laughton
<b>Position</b>	Chief Executive Officer
<b>Date</b>	
<b>Signed on behalf of Black Country Partnership Trust</b>	
<b>By</b>	Lesley Writtle
<b>Position</b>	Director of Operations
<b>Date</b>	
<b>Signed on behalf of Health and Wellbeing Board</b>	
<b>By</b>	Cllr R Lawrence
<b>Position</b>	Chair/Leader of the Council
<b>Date</b>	

### 1.3 Completeness and Accuracy Check

--

KLOE  
Ref.

1, 2

36

## 2. Vision and Outcomes

13, 14

### 2.1 Vision Statement

- 'Provide individuals and families in Wolverhampton with the services, methods and knowledge to help them live longer, healthier and more independent lives no matter where they live in the city. Health & Social Care colleagues will work better together, alongside local community organisations to deliver support closer to where individuals and families live and in line with their needs'. We have visualised this 'end-state' in Figure 1 below:-

Figure 1 – Wolverhampton's Vision/End State for 2020



- Our vision involves:-
  - **A fundamental transformation of health and social care in Wolverhampton** that will have a direct impact on reducing health inequalities and provide a better experience for the population of Wolverhampton.
  - **Care and support will be delivered closer to home and focus on promoting independence and prevention**, whilst providing a rapid health and social care response to persons where appropriate.
  - **Services being proactive in meeting population needs** and service developments that are evidenced based. Individuals will be empowered to take a more active role in managing their own care and support needs by making use of all assets available to them, not just those provided by statutory services.
- Figure 15 in **Section 8 – Integration, p46** demonstrates our vision of what integration will look like in Wolverhampton with a number of examples described around how this is currently

taking shape

## 2.2 What will success look like?

13, 14

Landscape Change	Demonstrated Through
People in Wolverhampton receive <b>seamless wrap-around services</b>	Through the delivery of <b>integrated, multi-disciplinary neighbourhood teams across three localities.</b>  <b>An increase in the number of people with identified care coordinators, a care plan, and contingency plan</b>
<b>Less people living permanently in Nursing &amp; Residential care, with more people receiving services in their own homes</b>	<b>Uplift in the number of services and support offered across 7 days and 24 hours</b> within the community
Those that remain in <b>Nursing &amp; Residential Care will have a named GP</b> (1 GP per Home unless patients choose otherwise), with agreed care plans for their Long Term Conditions and services designed to wrap around them, including access to Specialist Services historically provided in a hospital setting	<b>Number of patients who are resident in a nursing or residential home with a named GP – 100%</b>  <b>Clear transition of activity from hospital to the community</b>
<b>A planned reduction in the number of acute medical beds</b> , equivalent to 2 medical wards - one of which has already closed	Benefits realised through a <b>reduction in Delayed Transfers of Care (DTOC) and non-elective admissions</b>
<b>A shift of workforce numbers from acute settings into community services</b>	<b>Demonstrable activity shifts from hospital to community</b>  <b>Access to more services across 24 hrs., and 7 days</b> per week in communities  <b>Increase in self-management</b> and asset based community services being delivered in each neighbourhood
<b>People living with Long Term Conditions managing their own conditions – with the appropriate support</b> , taking control through personalised health and social care budgets and enjoying a better quality of life	<b>The number of active personal budgets</b>
<b>People with mental health problems identified early</b> - in the primary care setting - and early intervention commenced	<b>Increase in dementia diagnosis</b> <b>Increase in self-help and early intervention</b> services for mental health

## 2.3 Outcomes and Expected Improvements to Person Experience

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- In line with the vision **Wolverhampton has signed up to set of co-produced outcomes** that the programme is working towards across the life-course of our population:-
  - People will **live healthier lives for longer** and health inequalities will be reduced
  - People will receive the **care and support they require closer to where they live**
  - People will be **supported to stay at home for longer**, reducing reliance on residential and nursing care
  - People will be **more in control of the care and support they receive** through the continued development of personal budgets and individual service funds
  - People will have **one point of contact with a professional who will co-design the care plan with them**. The care / support will subsequently be **coordinated by a single professional** on behalf of the health and social care community neighbourhood teams
  - People will have **self-care and self-management treatment plans** which focus on maximising the potential for good quality independence
  - **More people will access community assets** to address fundamental wellbeing issues e.g. social isolation and depression
- In terms of the person experience we have engaged and listened to what matters (*Appendix 1 and 2*) and these are at the heart of our plans. *Figure 2* below outlines some of the significant findings. In addition, City of Wolverhampton Council has commenced a consultation on the Commissioning Strategy.

Figure 2 – Engagement Feedback



Source: Wolverhampton CCG 'You Said – We did' and Commissioning Intentions 2017-18'

## 2.4 Challenges

16, 17

- **Wolverhampton’s vision is rightly ambitious and brave, but both achievable and measurable.** The challenges we have to achieve success are significant, not least because some of the underlying root causes of demand across the current health, care and housing systems are influenced by current economic, social and demographic factors.
- What we do know and can accomplish is a **partnership approach across the city that crosses organisational and sector boundaries and goes directly into the heart of communities.** This presents us with the best opportunity to achieve success. We see the most significant challenges of achieving this to be:-
- **Significant financial pressures** and constraints across the public sector
- Clarity of understanding that the shifts outlined in the vision will be **long term and require patience to see the impact**
- **Effecting the changes in the culture, lifestyle and behaviour** of the population that can lead to more complex health and social care needs in later life. See [Section 3 – The Evidenced Based Case for Change, p13](#))
- **Creating a partnership culture and model across the health and care system that builds in the capability to flex over time** with shifting types of demand, growing populations and increased diversity
- **Creating a genuine partnership environment** within the context of often conflicting priorities, culture, financial constraints, political context, shifting public sector landscape and contractual arrangements
- **Alignment with STP** (See [Section 9, p51](#) of the plan for mitigation strategy)
- **Alignment with the emerging new models of Primary care in Wolverhampton.** The challenge here is that GPs have formed their models across locality boundaries and we need to continue working in partnership to ensure synergies with BCF model. To mitigate the above we have ensured a robust engagement strategy to ensure alignment and equity for the population of Wolverhampton and the GPs have agreed to move into localities.
- **This plan represents how we are beginning to meet these challenges in Wolverhampton and our plans to continue to do so going forward into 2017-19 and beyond**

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## 2.5 Vision Narrative

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- In common with the rest of England, **Wolverhampton’s health and social care economy is experiencing unprecedented demand and growth for services, with limited resources to meet those demands.** Despite progress in recent years, the resultant pressures are being reflected across the hospitals, GP surgeries, community healthcare teams and social services on a daily basis. **As the population grows and people live longer, the challenge to balance available resources and local needs will continue to grow.** Wolverhampton’s starting point for responding to this challenge is to not regard it as simply a financial issue or view pressures in one part of its public services as being resolvable in isolation from others. **The vision for the next 3 years is therefore nothing less than a continuation of the fundamental transformation of the quality and experience of care,** across all elements of commissioning and provision on behalf of Wolverhampton’s population.
- In line with the five year forward view, Wolverhampton CCG’s Primary Health Care Strategy

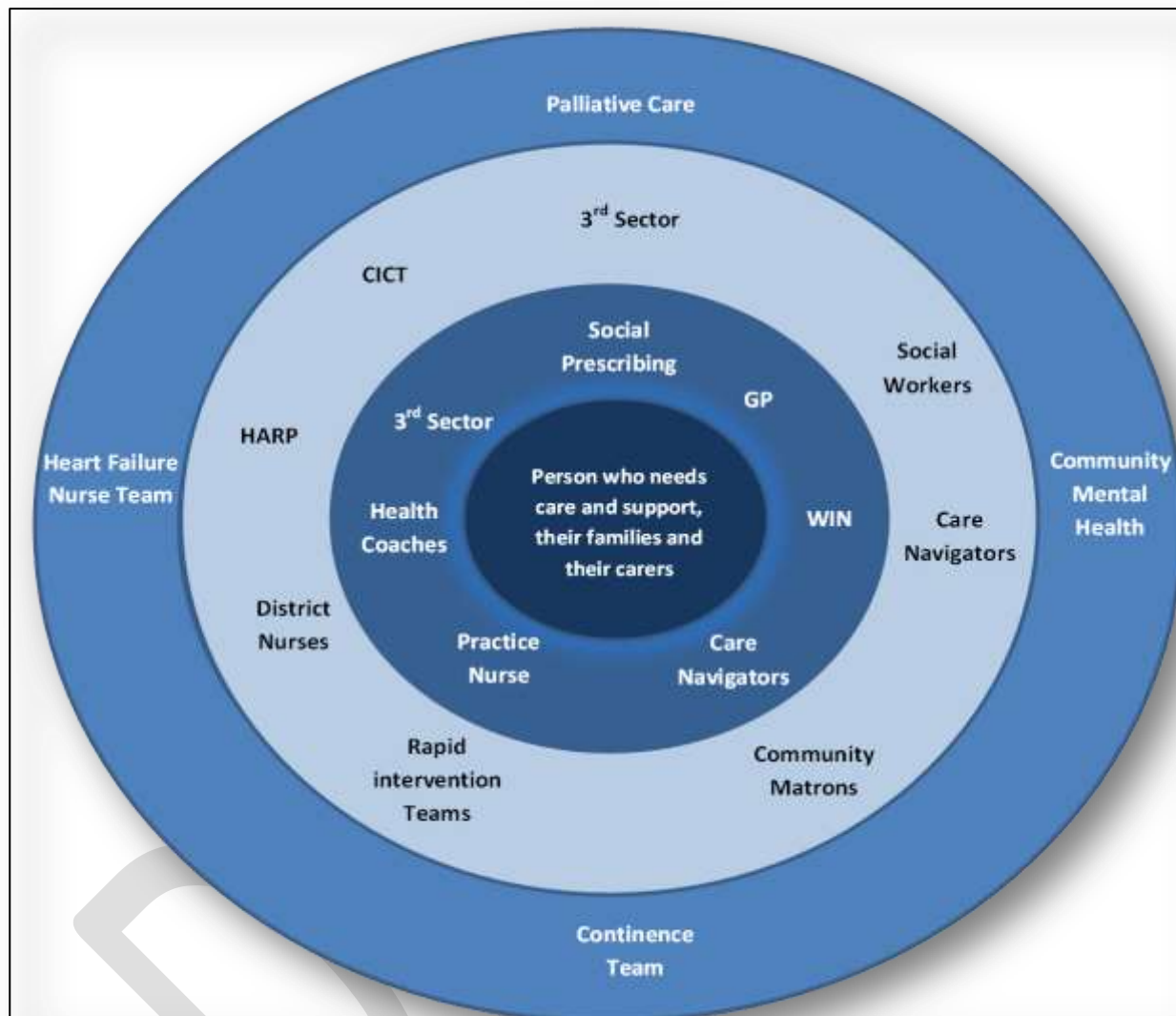
2016-20 (*Appendix 8*) describes a number of emerging new models of care in Wolverhampton that **BCF will proactively seek to ensure synergy** with. There are two groups of practices that are established as Primary Care Homes (PCH) that represent circa 60,000 of the population. A larger group of practices, currently representing circa 120,000 of the population function in line with a Medical Chamber model. The PCHs and the Medical Chamber group are all working towards MDT working. There are currently five GP practices representing a further 50,000 of the patient population who have subcontracted their General Medical Services (GMS) contract to the local acute and community provider. A further two practices are currently going through the due diligence process of aligning with the local acute and community provider. **From a person's perspective the Primary Care Home model describes that practices will offer "multi-speciality working through our 'Home', creating a 'one organisation' approach to delivering bespoke population health from a group of practices serving that community – whilst ensuring we retain personalised care for individuals, and continue to identify at risk person groups."**

- **Clearly the BCF programme will need to work closely with these models to ensure that care across the city is aligned.** It is the responsibility of current commissioners to ensure our services are developed and implemented in a way that makes them the preferred services for the new emerging organisations.

#### **Within the programme we will:**

- **Deliver holistic, person-centred care** (*Figure 3*) based on a population, place based approach. This ensures parity of esteem across physical, mental health and social care service.
- **Increase the diagnosis and management of people with Dementia** within a primary and community setting.
- **Deliver a range of services to support care closer to home**, promote confidence to enable **people to manage their own care** (this includes educating persons and carers of how to manage crisis situations) thus **enabling a reduction in A&E attendances and emergency admissions**. [See Section 5 – Delivery Model for details, p24.](#)
- **Actively promote a shared care approach with Primary Care professionals**, supporting Primary Care in the identification and case management of people identified at high/medium risk through MDTs and risk stratification
- **Be wrapped around Primary Care** based in our three localities supporting the emerging new models of care, to enable the delivery of a more localised approach to care closer to home.
- **Be multi-disciplinary across health and social care** in three localities to ensure equity of access and efficient use of wider community resources including the effective use of Information Technology
- **Work in collaboration with our Housing Partners to identify, scope out and develop any opportunities which would be enhanced by greater integration across Health, Social Care and Housing** that supports the outcomes and vision of the BCF Programme.

Figure 3: Person Centred Model of Care



## 2.6 Whole System Change

- **Wolverhampton’s vision for the future will require whole system change** e.g. how work is commissioned from providers to how providers interact with people and with each other. Wolverhampton is committed to effecting behavioural and attitudinal change in all areas by working together in partnership as a joint health and social care economy, with a central role for the voluntary, community sectors, and not least its citizens.
- This document sets out the joint commissioning intentions and areas for development. **It explains how local authorities and CCGs, working with people and communities, will mobilise resources to target areas of need and deliver improved outcomes in 2017-2019 and beyond.** It captures why this is needed, what the expected outcomes are on both an individual and locality-wide basis and the current best estimates of the specific investments required to make this happen.
- In doing so Wolverhampton’s plan is to go far beyond using BCF funding to back-fill existing

social care budgets, preferring instead **to work jointly to reduce long-term dependency across the health and social care systems, promote independence and drive improvement** in overall health and wellbeing for local people.

- **The volume of emergency activity in hospitals will be reduced as will the planned care activity in hospitals.** This will be achieved through the strengthening of alternative community-based services. A managed admissions and discharge process, fully integrated into local specialist provision and the Community Neighbourhood Teams (CNT's), will result in a minimisation of delays in transfers of care, reduced pressures in A&Es and wards, and ensure that after episodes of ill health, people are helped to regain their independence as quickly as possible.
- **Wolverhampton recognises that there is no such thing as integrated care without the inclusion of mental health services.** This in mind, the plans are designed to ensure that the work of community mental health teams is:-
  - Integrated with community health services and social care teams;
  - Organised around groups of practices;
  - Enables mental health specialists to support GPs and their persons in a similar way to physical health specialists.
- **In reviewing the Wolverhampton population demographics there are significant mental health needs for children and young people in the city.** On most indicators, the population of Wolverhampton scored significantly higher when compared to England averages. Measures include data on hospital admissions for self-harm, rate of children being looked after, first entrants into the youth justice system, and numbers of children living in poverty. Wolverhampton needs analysis data for CAMHS also describes under use of universal and targeted services at TIERS 1 and 2, causing over use of services at TIER 4. **Wolverhampton's vision is to re-balance activity across TIERS 1-4 by closing gaps, pump priming safe sound and supportive services whilst also increasing capacity and capability in early intervention and prevention services.** Future in Mind funding will be initially used to transform mental health services for children and young people by building capacity and capability mainly within specialist Child and Adolescent Mental Health Services at critical points, so that **by 2021 we can demonstrate measurable progress towards closing the health and wellbeing gap and securing sustainable improvements in children and young people's mental health outcomes**
- **By improving ways of working with people to manage their conditions, we will reduce the demand not just on acute hospital services but also on nursing and residential care.** BCF will continue to be used to:
  - **Help people self-manage** and provide peer support working in partnership with voluntary, community and long- term conditions groups e.g. Dementia Cafes.
  - **Invest in developing personalised health and care budgets** working with persons and frontline professionals to empower people to make informed decisions around their care.
  - **Implement routine person satisfaction surveying** to enable the capture and tracking of the experience of care.
  - **Invest in reablement and the use of Telecare** reducing hospital admissions and the overall budget for nursing and residential care.
  - **Reduce delayed discharges**, through investment in neuro-rehabilitation services, strengthen 7 day social care provision in hospitals and implementation of the Discharge to Assess pathway.
  - **Integrate NHS and social care systems around the NHS Number** to ensure frontline professionals, and ultimately all persons have access to all of the records and information they need.
  - **Undertake a full review of the use of technology** to support primary and secondary



prevention, enable self-management, improve access and service experience, and release professional resources to focus on those in greatest need. An example being the enhancement to the Wolverhampton Information Network (WIN) in the summer of 2017, which is a free web based signposting facility that enables the public and medical professionals to benefit from a comprehensive view of local services covering the entire spectrum from health, through social care, and community. This can be either via self-service or through sign-posting by health care professionals.

- **Developing a new model of joined-up care will require a physical and cultural shift with new ways of working and new ways of thinking.** Previously, Wolverhampton's health and social care system has taken a reactive approach to managing the care of people in crisis often leading to a hospital admission and a journey in to long term care. **Since the implementation of the BCF Programme this has begun to change to a more positive and joined-up experience of care and a more proactive approach. We are aware, however, that much more improvement can be made.** The CCG Strategic Plan sets out its intent to put the health and care economy on a sustainable footing, through developing community-based services and addressing the default of receiving care in acute settings. This is also in the context of City of Wolverhampton Council (CWC) needing to save in excess of £54.2 million over the next 3 years. **To address this, both organisations will be working in partnership, with a CCG focus on increasing capacity in primary care and council focus on strengthening the community reablement offer.**
- The **BCF programme aims to reduce the number of people treated in hospital who could be treated more effectively in, or closer to their own homes.** It also **aims to reduce the number of people attending hospital at the point of crisis** by focusing on how to prevent the crisis happening. Wolverhampton wants to **encourage people to take control and lead healthier lives.** The assets of local communities will also play a big role in helping people to access different types of support closer to where they live. The mapping of community assets to ensure they can become part of how we plan care with people has begun and will continue up until 2020

## 2.7 Underpinning Support for our Vision

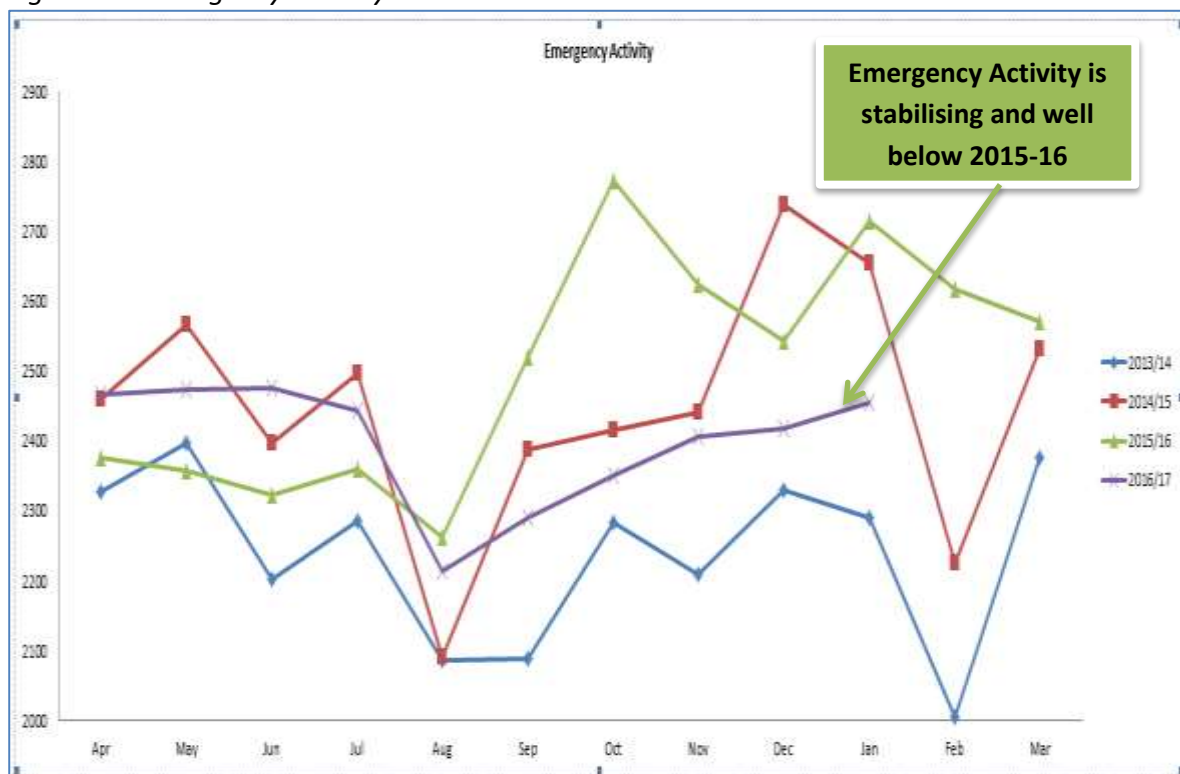
- Wolverhampton's vision for health and social care services for its community is **underpinned by:**
  - **The jointly agreed and developed Health and Wellbeing Strategy.** (Appendix 3)
  - **Effective engagement with the local community** and listening to what they have told us (Appendix 1 'Commissioning Intentions 2017-18' and Appendix 2 'You Said-We Did' )
  - **Wolverhampton CCG Operating Plan 2015-2017** (Appendix 4)
  - **The Council's Corporate Plan and 'Our Vision Our City - Our Vision for the City of Wolverhampton in 2030'** (Appendix 5 and 6)
  - The evidence base regarding the future needs of the population of Wolverhampton through the **JSNA** (Appendix 7)
  - **Wolverhampton CCG Primary Health Care Strategy 2016-2020** (Appendix 8)
  - **Neighbourhoods, Homes & People-Wolverhampton Housing Strategy 2013-18** (Appendix 9)
  - **The Council also is consulting on a draft People Directorate Commissioning Strategy.** This brings together transformation activity across children and young people services, adult care services and public health. Commissioning intentions are proposed through which well-being, strengthening prevention, and ensuring care for all people are all promoted. Close partnership working is needed to deliver the commissioning intentions and the BCF has given us an environment in which to integrate further and align Council and CCG commissioning intentions.
  - **The Black Country Sustainability and Transformation Plan 2016** (Appendix 10)

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## 2.8 Progress and achievements over past 12 Months

- As outlined in the challenges to achieving the vision it will be take patience to see the full impact of the transformation, however **it is vital that we do measure, demonstrate and celebrate the progress** that Wolverhampton has made on the journey so far. Whilst more detail on this can be found in [Section 6 – Reflection on 2016-17, p31](#) significant aspects of our progress are:-
- **Reduction in emergency activity** and significantly less variation in the system **indicating greater system stability and control** has been established (see Figure 4 below)

Figure 4 – Emergency Activity over Time



- **Rapid Intervention Team (RITs)** – This service has moved from pilot phase to business as usual and is now operating as a 7 day admission avoidance service and is now accepting referrals from West Midlands Ambulance Service
- **Risk Stratification** – Community Matrons working with GPs to identify persons of high risk of admission and proactively manage their care. The next phase will be to work with medium risk patients to stem the flow and dependency on acute care
- **Integrated Health and Social Care Multi-Disciplinary Team working** – 3 Locality based MDTs, meeting on a monthly basis to discuss an identified caseload of persons.
- **Wound Care Pathway** – development of a multiagency Wound Care Pathway
- **End of Life Pathway** – development of a multiagency End Of Life Care pathway
- **Mental Health** – development of Street Triage and a prevention focused service called ‘Starfish’
- **Discharge to Assess (D2A)** – Establishment of a D2A project to develop and implement an Integrated D2A pathway
- **Memory Matters** – Establishment and rollout of Advice and Information clinics across the city for people who are concerned about memory issues and possible dementia delivered from non-health buildings
- **Dementia** - A business case was agreed by the A&E Board to ‘pump prime’ service

transformation by increasing the number of dedicated liaison and outreach dementia staff across RWT and by increasing the remit of their role to pro-actively assess and navigate the required next steps for patients with dementia or suspected dementia presenting in RWT

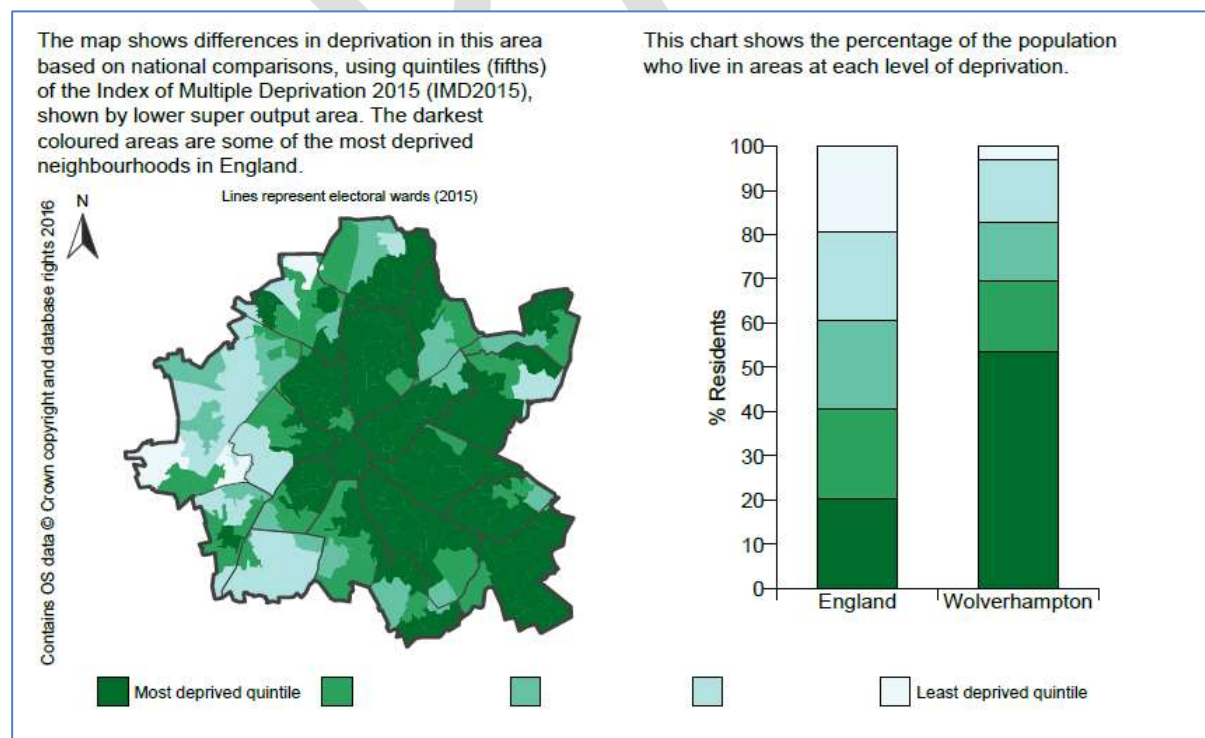
- **Social Prescribing** – Partnership working with Wolverhampton Voluntary Sector Council to deliver a 12 month Social Prescribing pilot
- **WIN – Enhancement of the Wolverhampton Information Network** to create a single information portal for health, social care, voluntary and community services
- **Data Sharing Agreement** – City wide data sharing agreement approve to enable Integrated teams to work more effectively
- **Fibonacci** – the implementation of an IT system allowing members of MDT to view health and social care data

### 3. Evidenced Based Case for Change

#### 3.1 The Economic Challenge

- **The Wolverhampton economy as a whole is financially challenged.** All key partners are experiencing significant financial challenges now and in forthcoming years. In the CCG the Quality Innovation, Productivity and Prevention (QIPP) delivery programme has a current 4 year plan of £35-40million savings that need to be made alongside the savings target for CWC over the next 3 financial years of in excess of £54 million.
- **Wolverhampton as a city area experiences more than twice the level of most significant deprivation than the national average, and proportionately much lower areas of prosperity.** As demonstrated in the wider determinants of health, those deprived are more likely to have lower life expectancies and earlier disease manifestations. *Figure 5* below shows the deprivation level comparator between Wolverhampton and the rest of England, the darker the green the more deprived.

Figure 5 – Deprivation in Wolverhampton



- The entire health and social care community in Wolverhampton understands that **in order to gain the most value from its joint investment, the BCF is the opportunity**, particularly around

community based services, to pool its resources. For the CCG, this means enacting its strategic intentions to transfer appropriate elements of care from a hospital setting into the community as well as reviewing and transforming existing community based services to deliver the most significant demonstrable quality and value.

## 3.2 Drivers creating demand in Wolverhampton

### 3.2.1 Executive Summary

- The evidence from Public Health, JSNA and clinical data sources indicate a **likely increase in demand for health and social care services in Wolverhampton** as a result of a forecast increase in the numbers of older adults with comorbid health problems of a complex nature alongside challenging social care needs. The information depicts a current Wolverhampton population:-
  - **Projected to increase**, including a **forecast 95% growth rate in the 85+ age range** rising from 6,000 in 2014 to 11,700 in 2039.
  - With **over half falling amongst the most deprived** in the country. Wolverhampton remains the 21<sup>st</sup> most deprived Local Authority district in the country (*DCLG The English Indices of Deprivation 2015*)
  - With a greater than ever life expectancy **but no corresponding increase in healthy life expectancy (JSNA)**. As they grow older, the longer people remain healthy, the less growth in demand for health and social care services there will be. **The pressure of an aging population is not in itself the key factor but rather how healthy people are.**
  - That can **expect to live on average 2 years less** than the England average (*JSNA*)
  - With a **Health Summary that is statistically amongst England's worst** (*Health Profile 2016, Public Health England*) where **31% are currently registered on a chronic condition register** and, **27.7% have one or more long term conditions** (*Moving care closer to home, Business Case*) and **over 64% of adults over 60 are living with frailty** (*Wolverhampton Frail Elderly Workshop, March 2017*)
  - That has **significant health inequalities** across the city and ethnicities (*Health Profile 2016, Public Health England*).
  - Where other than cancers of all types, **Cardiovascular Disease (CVD) remains the single greatest cause of lost life years** and although this is improving over time, mortality from CVD remains considerably higher than the national and west midlands average (*JSNA*).
  - As of September 2016, the **recorded prevalence of Dementia in those aged 65 and over in Wolverhampton (4.94%) was significantly higher compared to England (4.31%) and the West Midlands (4.14%) (JSNA)**.
  - The **Dementia diagnosis rate in October 2016 was higher in Wolverhampton compared to the England average.** (JSNA) **what is the dementia diagnosis rate? Andrew Woods**
  - The **rate of emergency admissions with a mention of Dementia in Wolverhampton were significantly higher compared to England and the West Midlands**, at the most recent data point (2015-16).(JSNA).
- Addressing these issues within the context of financial constraints and the local economic climate represents a significant challenge where **doing nothing is not an option**

### 3.2.2 Population Forecast

- The Sub-National population projections to 2020 suggest an increase in the resident population with growth set to continue even further ahead to a projected estimate of Wolverhampton's population in 2039 as 288,000 with growth being most rapid in the child and older populations. These estimates show:
  - **The number of people aged 65 years and over is projected to grow** from 42,400 in 2014 to

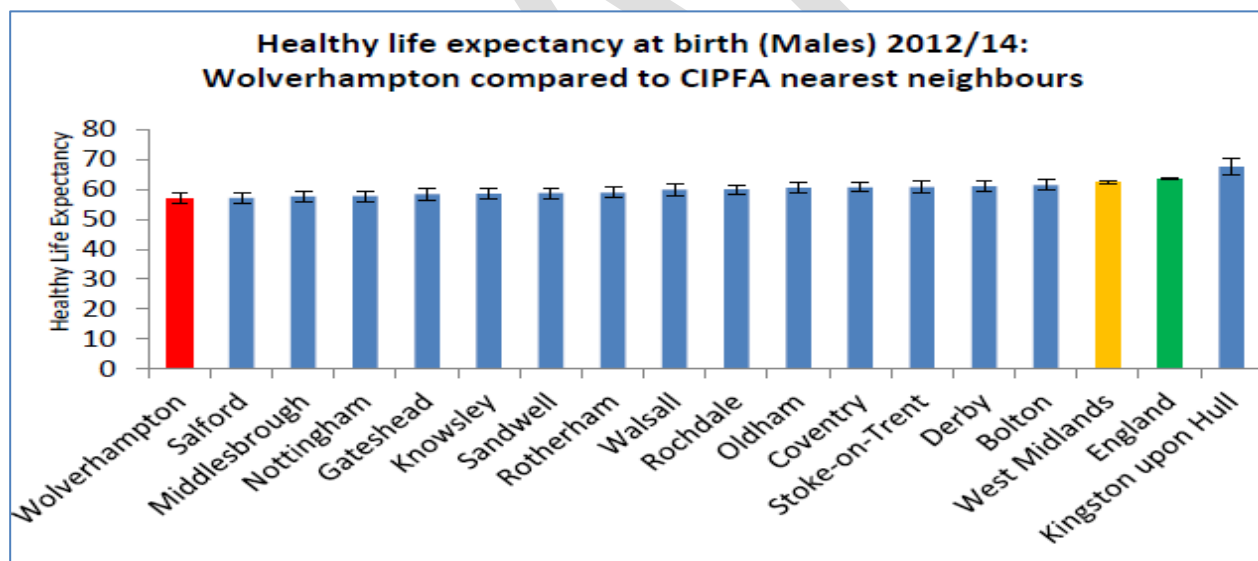
60,500 in 2039: a gain of 18,100 (42.7% growth).

- **The number aged 85 years or older is shown to grow by 5,700 (95.0% growth)**, from 6,000 in 2014 to 11,700 in 2039.
- The number of children (aged 0 to 15 years) is projected to increase from 51,300 in 2014 to 59,000 in 2039. This is a net gain of about 7,700 (15.0% growth)
- The number of people aged 16 to 64 years is projected to rise slightly from 159,400 in 2014 to 168,500 in 2039. This is a net gain of about 9,100 (5.7% growth).

### 3.2.3 Life Expectancy and Health Inequality

- The Joint Strategic Needs Assessment (JSNA) (Appendix 7) for Wolverhampton shows that although overall life expectancy in the city has improved over the last 12 years, **it is still some way below the national averages for both sexes with a significant health inequality gap** remaining in the city.
- Life expectancy in Wolverhampton is currently 77.6 years for males and 81.8 years for females, **which is almost two years less than the national average for both.**
- Healthy life expectancy in Wolverhampton **is almost six years less than the national average** for both sexes. Males can expect a healthy life expectancy of just over 56.9 years which is **currently the worst of all our statistical comparators** (See Figure 6). Females have a healthy life expectancy of 58.3, which is also amongst the worst of all our statistical comparators.

Figure 6 – Healthy Life Expectancy for Males



- **The gap in life expectancy between the most and least deprived areas in the city is increasing.** The latest statistical information can be found below in (see Figure 7)
- **The Black Minority population is over represented in relation to emergency hospital admissions Ethnic (BME - using the definition of BME as non-White residents), see figure 8.** This suggests that some people are not accessing or receiving the care most suited to managing their condition, and are therefore further disadvantaged. 32% of Wolverhampton's residents are classified as being from BME backgrounds; the largest is Asian at 18%, followed by black and mixed race at 6.9% and 5.1% respectively. This diversity is higher than the national distribution where 14.6% of the population is classified from a BME community. In addition, Wolverhampton has an increasing growth population from Eastern Europe. **Equality Lead – Juliet Herbert**

- The BCF plans to reduce health inequalities in the city by the implementation of the person centred model of care (Figure 3). In addition each workstream is required to complete Equality Impact Assessments for any project work undertaken as an integral part of the governance processes

Figure 7 - Health In-equality – Life Expectancy Gap across the City

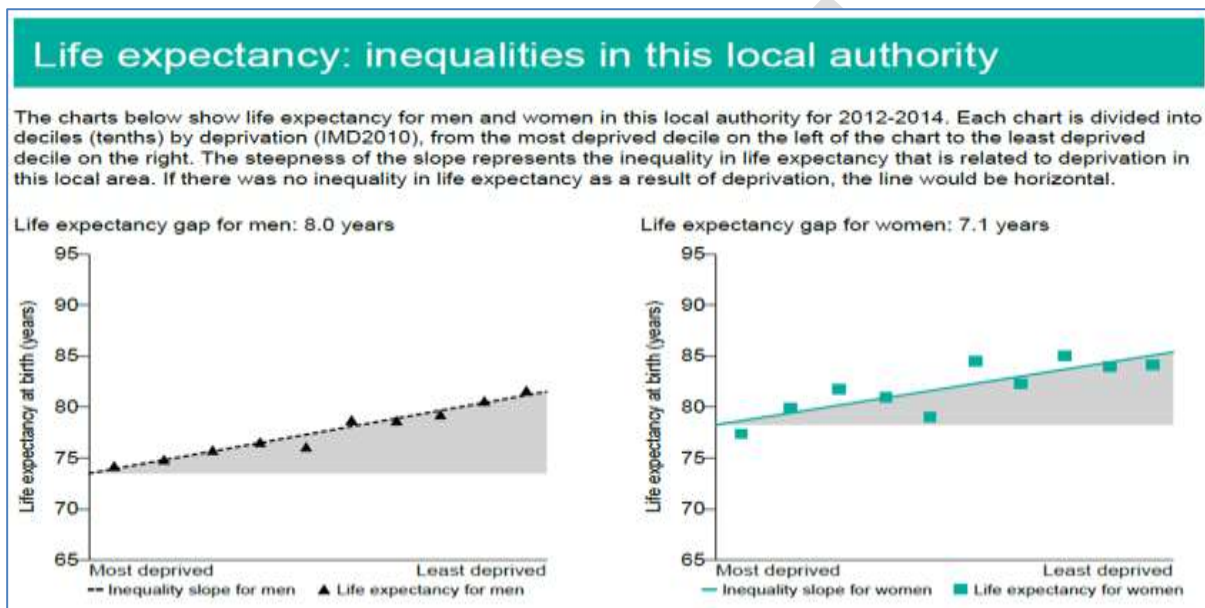
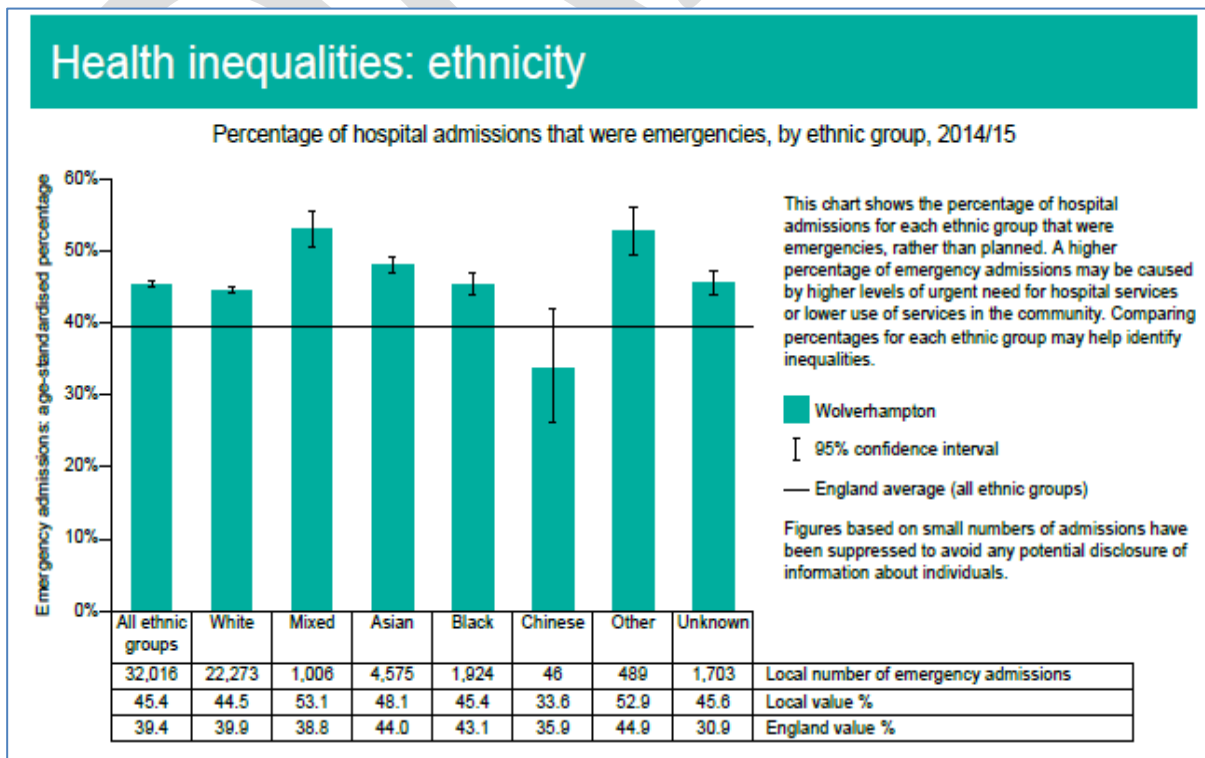


Figure 8 - Health In-equality – Ethnicity



### 3.2.4 Health Summary and Long Term Conditions

- **Wolverhampton benchmarks very poorly against a number of significant health factors and the wider determinants of health** (See *Figure 9* below) that typically contribute to a life limiting illness, frailty and/or long term medical condition later in life e.g. smoking, obesity and alcohol consumption
- Highlighted areas of demand suggest **that a significant proportion of the Wolverhampton population – 16.1% - have a long term condition** (See *Figure 10, p18*), with 11.6% having more than one long term condition; in total 27.7%, with 79% of those people with a single long term condition being within the 16-69 age range, and 53% of those with more than one long term condition are represented in this age range. Whilst this sits within the national average range, the growth expectations regarding the over 85 population suggest that Wolverhampton will experience a potential increase in the numbers of older adults with comorbid health problems of a complex nature, and with challenging social care needs.
- A further indication of a likely increase in demand is suggested from information extracted from primary care clinical systems that currently indicates approximately **82,000 adults aged 18 and over (approximately 31% of total population) that are currently registered on a chronic condition register** which equate to nationally derived QOF cohort counts (including diabetes, asthma, heart disease, lung disease, dementia, stroke and arthritis) and an increasing number will develop these conditions as they grow older.
- Primary care data using the Electronic Frailty Index (eFI) indicates **over 64% (37,880 individuals) of the over 60 population in Wolverhampton are living with frailty** with a further 26.6% (18,437 individuals) aged between 49 and 60 (*Wolverhampton Frail Elderly Workshop, March 2017*).
- In reviewing the Wolverhampton population demographics **there are significant mental health needs for children and young people in the city.** On most indicators, **the population of Wolverhampton scored significantly higher when compared to England averages.** Measures include data on hospital admissions for self-harm, rate of children being looked after, first entrants into the youth justice system, and numbers of children living in poverty. **Wolverhampton needs analysis data for CAMHS also describes under use of universal and targeted services at TIERS 1 and 2, causing over use of services at TIER 4.**

*Figure 9 – Health Summary*

## Health summary for Wolverhampton

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

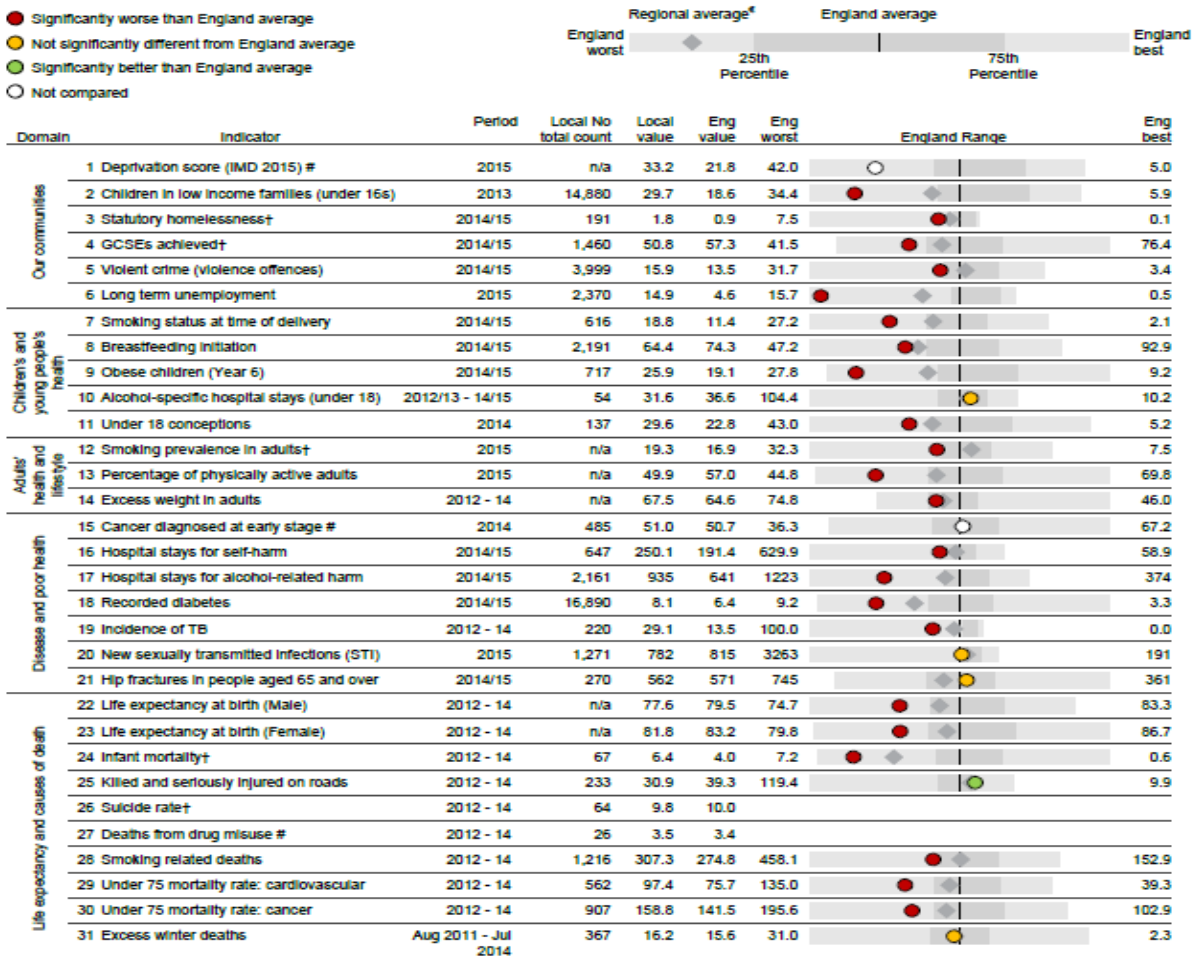


Figure 10 – Long Term Conditions

Estimated Wolverhampton population breakdown based local data									
	Mostly healthy	1 LTC	Multiple LTCs	SEMI	Dementia	Cancer	Learning Disability	Physical Disability	Grand Total
Child	48,616	2,411	13	8	-	34	-	108	51,190
16-69	121,308	33,630	16,380	2,200	142	2,897	968	1,791	179,316
70+	5,234	6,169	14,070	361	1,725	3,257	45	413	31,274
Grand Total	175,158	42,210	30,463	2,569	1,867	6,188	1,013	2,312	261,780

- The assumption from this data and the current data analysis regarding emergency admission activity is **that there is a need to plan for an increasingly health challenged aging population with complexity and co morbid conditions**. Alongside this is an **absolute need to adopt an early intervention, self-care management and prevention approach to support this population** over the coming years positively to live well and with general good health.
- As described in the CCG operating plan **our overriding aim is to enable people to live longer and more healthily**. Although life expectancy is increasing we need to ensure that people enjoy disability free years of live as well as having increasing longevity. **The increasing problem of the**



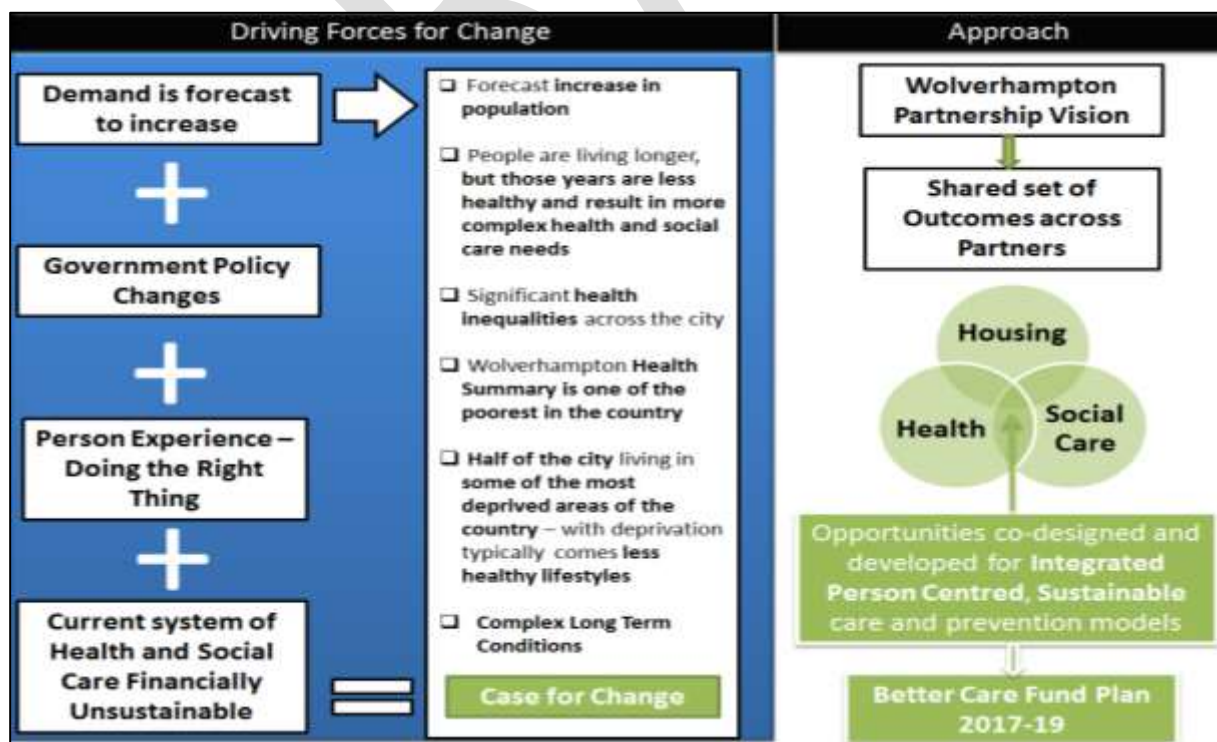
frail elderly population means that we have to look at specific services to support people to remain in their own homes and to receive care closer to home where appropriate. We are working together as a health and social care economy to try to address these issues.

- In line with the seven NHS ambitions detailed in the NHS outcomes framework we aim to improve the quality of life of people with one or more long term condition, including mental health conditions.

### 3.2.5 Conclusion

- The insight that is available on the demographics, JSNA and Health Summary for Wolverhampton all provide a strong indication of the likely increase in demand for Health and Social Care services in the future. When reconciled with the economic challenges that are presenting both regionally and nationally this rise in demand will be unaffordable and unsustainable without significant transformation of the health and social care landscape (see Figure 11 below).
- As a component part of the wider public and voluntary sector system (and acting within those constraints) our BCF plan aims to redesign the model of health and social care delivery in Wolverhampton where our insight tells us that we can make the most difference in terms of person experience, preventing demand in the first place (where appropriate and right for the person) and where we can make the best use of our scarce resources once people need more complex health and social care needs. **It is on these principles that our plan to address the challenges are built and measured.**

Figure 11 – The Case for Change

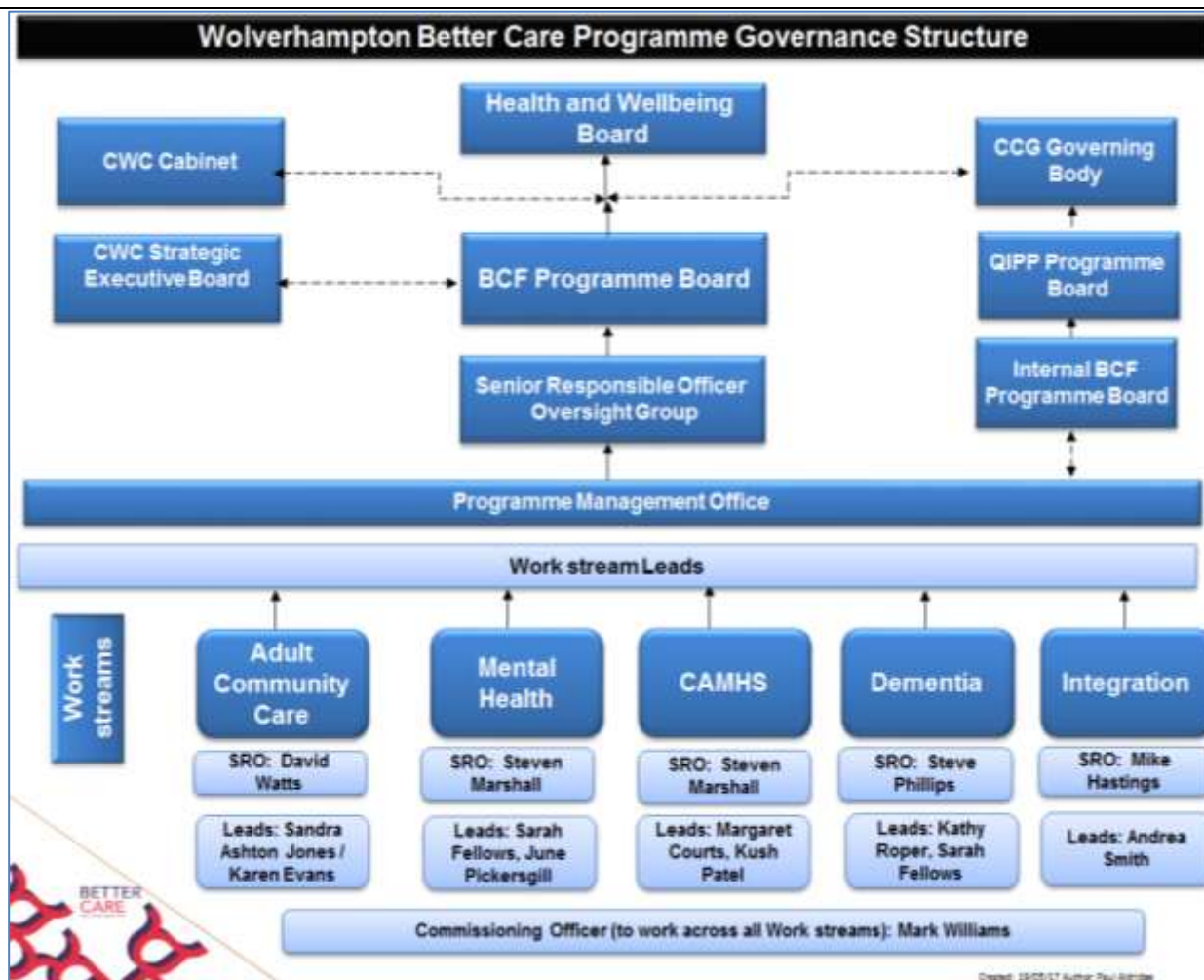


## 4. Programme Delivery Method and Control

### 4.1 Overarching Governance Arrangements

- Wolverhampton's BCF is overseen by the HWB. The specific BCF programme of is managed through the BCF Programme Board which is co-chaired by the Accountable Officer at the Wolverhampton CCG and the Strategic Director (People Directorate) for CWC.
- The programme is underpinned by a refreshed formal Section 75 agreement between CWC and Wolverhampton CCG. Membership of the HWB will be reviewed in order to reflect the requirements of the Section 75 agreement and the robustness of approach it will need to take.
- The governance arrangements for the BCF are as streamlined as possible, bearing in mind the scale of the financial commitment involved and the scope of the overall project. Day to day operational management and oversight of the fund will be the responsibility of the BCF Programme Board. Each workstream within the Programme has an allocated Senior Responsible Officer and workstream leads from the key organisations involved in that work stream. Members of BCF Programme Board have delegated responsibility from both partner organisations to hold the Senior Responsible Owners to account and make necessary decisions from a planning and performance management perspective.
- The Senior Responsible Officers provide oversight and monitoring of the Pooled budget, supported by their respective organisation Finance leads.
- *Figure 12* below demonstrates the structure that provides the delivery mechanism and Governance to the Programme. CCG, LA and Provider organisations are represented at each of the levels of the structure except for the PMO which is a joint CCG and LA function. Both organisations resource a Programme and Project Manager and there is a jointly funded Project Support post.

*Figure 12 – Wolverhampton BCF Governance Structure*



#### 4.2 Wolverhampton's Governance Flow Management and Oversight

- Wolverhampton CCG and CWC have co-terminus boundaries, and as such, have an element of already established oversight and management arrangements. Nevertheless, in relation to the BCF Programme, and in order to support the wide transformation agenda and current joint commissioning arrangements across the City, the two commissioning organisations have recognised the need to establish a clear and explicit governance framework which adds value to the existing partnership mechanisms.
- At the heart of the arrangements is the HWB, which, as mandated by the BCF Framework, has overarching accountability and oversight of the BCF Plan. Both CWC's Cabinet, and Wolverhampton CCG, have issued initial delegated authority to the Board for this oversight on behalf of the 2 organisations, with the HWB now being enhanced by additional elected membership.

#### 4.3 Section 75

- Underpinning the management and oversight of the BCF Programme is the development of a Section 75 agreement. Wolverhampton currently has established joint commissioning arrangements in relation to mental health, learning disability, and all age disability. The Specific Section 75 agreement for BCF will cover:-
  - The complexity of the role of the HWB in relation to Section 75 oversight (i.e. the requirement for a change to Council constitution, and the Boards broader remit)
  - Risk sharing
  - Specific inclusion requirements
- These governance arrangements will ensure that there is sufficient authority to take

appropriate decisions and scrutiny of those decisions and the operation of the arrangements generally. The governance arrangements have been developed over the last 12 months, and clearly articulate the reporting requirements. They will be set out in full in Schedule 2 of the Section 75 agreement. Existing contracts between the CCG and providers and the Council and their respective providers will not be affected by the continuation of a single host for the pooled fund.

#### 4.4 Pooled Fund Management

- Each individual work stream where there is a pooled fund has designated pooled fund management from both a health and social care perspective (commissioner). This role is undertaken by existing commissioners within each of the statutory partners, with the following duties and responsibilities:
  - The day to day operation and management of the pooled fund
  - Ensuring that all expenditure from the pooled fund is in accordance with the provisions of the Section 75 agreement and the relevant scheme specification
  - Maintaining an overview of all joint financial issues affecting the Council and the CCG in relation to the services and the pooled fund
  - Ensuring that full and proper records for accounting purposes are kept in respect of the pooled fund
- Reporting to the Commissioning Executive Group (CEG) as required (this would be through SROs)
- Ensuring action is taken to manage any projected under or overspends relating to the pooled fund in accordance with the Section 75 agreement
- In conjunction with the overall pooled fund manager preparing and submitting to the HWB/Integrated Commissioning and Partnership Board quarterly reports (or more frequent reports if required) and an annual return about the income and expenditure from the pooled fund together with such other information as may be required by the HWB to monitor the effectiveness of the BCF and to enable the CCG and the Council to complete their own financial accounts and returns
- In conjunction with the overall pooled fund manager, preparing and submitting performance reports to the HWB on a quarterly basis (per Section 75 paragraph above)

#### 4.5 Metrics and Performance Tools

- Wolverhampton's health and social care community acknowledges the need to respond to the scale and pace of the BCF Programme with a governance and management oversight infrastructure that is robust and has clear lines of accountability. Supporting the roles of the management and oversight infrastructure is a portfolio of metrics in a developing dashboard. This will provide 'at a glance' oversight of work stream delivery against programme objectives, risks, mitigations and benefits realisation on a programme wide basis. These are outlined in the table below:

KLOE  
Ref.

Management Oversight Tool	Reporting To	When
Workstream Dashboard – Metric Impact	BCF Programme Board	Monthly
Programme Plan Highlight Report, Risks and Escalations	Programme Office	Monthly
Aggregated Performance Dashboard	BCF Programme Board and Health and Wellbeing Board	Monthly
Risk and Mitigations Exception Reports	Senior Responsible Owners	Monthly
Engagement and Communication Report	BCF Programme Board	Monthly
Performance report	Workstream	Monthly

#### 4.6 Risks, Risk Share and Management of Risk

- Risks are identified (via risk log), analysed (typically using likelihood/impact matrix) and managed across the programme from individual project level through to workstreams and ultimately up to Programme level where significant risks are reported to and managed by the BCF Programme Board. Key stakeholders are represented at each of the levels.
- Alleviation of risk for providers relies heavily on understanding the commissioning intentions of the commissioning bodies. Wolverhampton commissioning intentions for both the council and the CCG are published in line with national timeframes and organisational requirements. Detailed discussions between commissioner and provider are undertaken during contract negotiations which fully address risk for providers.
- A comprehensive risk review has been undertaken across the 2017/19 programme. In each case where a risk was identified, thought was given to potential mitigations that would alleviate, assist or resolve the risk should it develop into an issue for any given provider. For the two NHS Trusts, much of this work has been addressed via contract negotiations, Commissioning for Quality and Innovation Payments Framework (CQUINS) and negotiated solutions using internal processes.
- The financial risk identified by the programme risk review are summarised below and can be confirmed as not putting any element of the minimum contribution to social care or iBCF grant at risk:-

	CCG Risk%	Council Risk %
Adults Community Service	53	47
Dementia	90	10
Mental Health and CAMHS	65	35
Demographic Growth	56	44

- The 2017/19 pooled fund agreement has been achieved through a transparent process of sharing detailed projections, outturn information, and data and looking carefully at those areas of the whole Health and Social Care system that when pooled could create “cause and effect”. This approach has allowed both Wolverhampton CCG and the CWC to develop a shared incentive for overall agreement. As referred to earlier in the document the pooled fund for Wolverhampton during 2017/19 will be £10.934m. This is broken down across the following

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23, 24

work streams:

Work streams	CCG Funded services (£000)	Council Funded services (£000)	Total Services (£000)
Adult Community Services ( <b>Note: includes iBCF Funding within Council Funded services</b> )	29,086	25,644	54,730
Dementia	2,627	282	2,909
Mental Health	5,313	2,809	8,122
CAMHS	839	470	1,309
Ring Fenced Capital Grants – DFG	0	2,678	2,678
Care Act Funding (TBC)	964	0	964
<b>Total</b>	<b>38,829</b>	<b>31,883</b>	<b>70,712</b>

#### 4.7 Risk Share – Underperformance

- The proposed revenue value of the pooled fund to be managed via the Section 75 agreement is £67.070m and consists of £37.865m of CCG funded services alongside £29.205m council funded services. The council contribution includes £6.513m for 17/18 and £6.637m for 18/19 representing the NHS transfer to social care (Section 256 funding). The pooled budget also includes a capital grant amounting to £2.678 m which is managed by the council.

#### 4.8 Risk Share – Overspend

- The host organisation (CWC) will produce monthly financial reports and share these with the other party. The first reconciliation to recoup any overspend shall take place at quarter two (month six), and quarter three (month nine). Month 11 reporting will incorporate year end estimates on the pool fund.
- The BCF Programme Board shall consider what action to take in respect of any actual or potential overspends. The Board will take into consideration all relevant factors including, where appropriate the BCF Plan and any agreed outcomes and any other budgetary constraints and agree appropriate action in relation to overspends which may include the following:
  - Whether there is any action that can be taken in order to contain expenditure;
  - Whether there are any underspends that can be vired from any other fund maintained under this Agreement;
  - How any overspend shall be apportioned between the partners, such apportionment to be determined on the basis of the individual partner's contribution to the individual work stream as detailed in the table above.

#### 4.9 Non-financial Risks

- The major areas of non-financial risk sharing specifically within the BCF largely relate to performance against targets, information governance and equalities. Each of these key areas were identified at the very start of the BCF journey.
- Performance against targets.** The programme is well structured and managed. Work streams meet on a face-to-face basis fortnightly and management of activity and progress is documented and shared via the maintenance of comprehensive project management toolkits (critical paths, implementation plans, action, risk, issue and escalation logs) supplemented by highlight reports to programme board. Performance is measured against targets through

4

routine collections of data by each organisation's Business Intelligence team and reported to the programme board monthly. This allows for early identification of issues which enables proactive management at appropriate levels of the governance arrangements.

- **Information Governance and Equalities.** An overarching Information Sharing Agreement has been created to support the shared care approach we are working towards here in Wolverhampton. An agreement has been reached for the four main partners to install, gain access and utilise a software platform that allows frontline workers to comprehensively 'view' client data across all available systems for identified purposes. Given that this is a 'view only' solution that does not allow any changes to already stored data, this is a real step forward in the professional health and social care world. Existing information and data cannot be compromised and therefore the four BCF partners have each agreed a 25% financial cost and associated risk share arrangement. This ability for professionals to instantly access a person's health and social care information irrespective of their employing organisation will profoundly affect the timeliness of treatment and support available to those people in need, reducing the risk of duplication and gaps in service
- **With regard to equalities,** impact assessments are undertaken for each project and are continually reviewed and refreshed as required.
- **Other non-financial risk** sharing agreements sit largely across the BCF organisational partners as service level agreements rather within the Programme itself. These service level agreements relate to a variety of processes and practices across the health and social care economy the key ones relating to timeframes for:
  - Hospital discharge
  - Service response
  - Service quality

## 5. Delivery Model

### 5.1 Summary

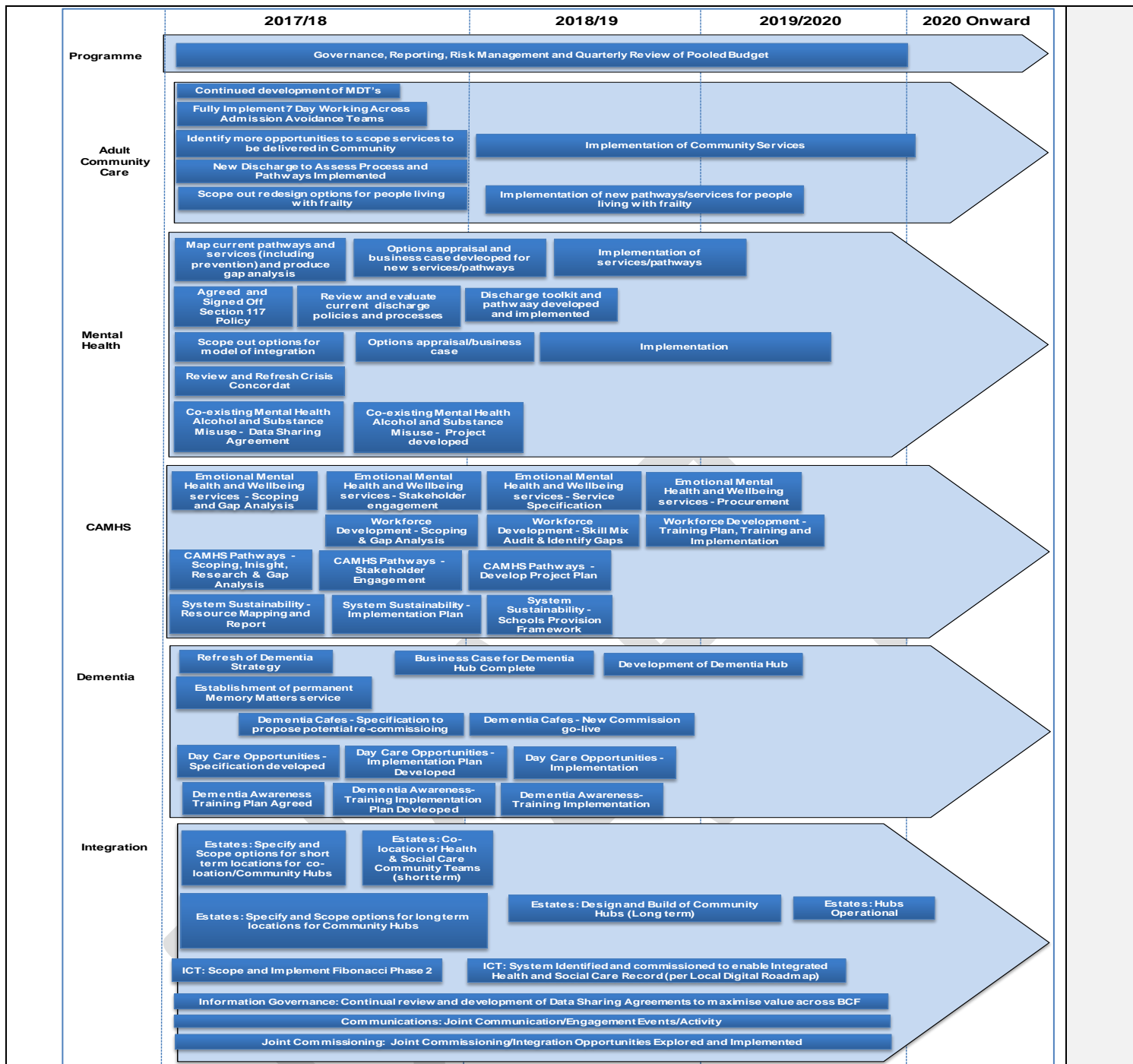
- We have a number of programmes of work which are designing and developing services across Wolverhampton as part of our BCF approach (*see Figure 13 - Strategic High Level Roadmap*). These have been established over two years and have engaged health and social care provider organisations, commissioners, the voluntary sector, GPs, local forums and front line staff to contribute towards a review and redesign of services enabling us to deliver on the national performance metrics:-
  - **Reducing emergency admissions** to hospital
  - **Reducing the number of delayed transfers of care** from hospital
  - **Improving the effectiveness of reablement**
  - **Reducing the number of people permanently placed in nursing and residential care**
- **Our aim is to have integrated health and social care teams, supported by Voluntary Sector and community groups, wrapped around GP practices and their individuals to provide place based co-ordinated proactive and reactive case management for people with medium to high level of need, long term conditions and who live with frailty.** They will be co-located in community hubs which will be developed to underpin this vision. The hubs will contain integrated health and social care teams working together to develop person centred interventions within the community they serve. The plan is for there to be one hub in each of the three localities across the city, however we are increasingly mindful of the emerging New Models of Primary Care and are working closely with the GP groups to ensure that development of the teams is also reflective of the Primary Care landscape.

- **These teams are currently working virtually and hold Multi-Disciplinary Team meetings on a monthly basis in all three localities** whereby the health and social care teams discuss in detail their caseload of people with complex and interdependent needs, ensuring that appropriate care is being co-ordinated and delivered.
- **The teams will work alongside the numerous stakeholders such as the individual's GP, Voluntary Sector, specialist teams, the Police, West Midlands Ambulance Service, West Midlands Fire Service and local pharmacies** delivering both proactive and reactive models of care depending upon the person's needs.
- **We aim to build a neighbourhood approach which generates self-care, early identification and screening, integration and resilience of communities.** Delivering a person centred focus to support for those who are living with frailty and/or complex health and care needs which maximises their independence and enables people to remain in the home they are ordinarily resident for as long as possible.

*Figure 13 – High Level Strategic Roadmap 2017-2019*

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## 5.2 Proactive approach

- The proactive approach aims to identify those individuals presenting with high demand for services and at risk of attendance at A&E and emergency admission. **By identifying these people early we aim to provide support that educates and empowers them to understand and manage their condition more effectively** with the support of our community neighbourhood teams, Primary Care and Social Prescribing teams.
- **For Social Prescribing, Wolverhampton CCG in partnership with Wolverhampton Voluntary Sector Council, have launched a twelve month Social Prescribing Pilot** to provide an alternative to and compliment Primary Care. The service will work closely with other agencies in order to maximise the options available to individuals (i.e. voluntary sector organisations, Local Authority, and the local NHS provider Trusts). Each practice will have a named Social Prescribing Link Worker. The Social Prescribing Pilot will work very closely with Primary Care and aims to be anticipatory, preventive and proactive in its approach:-

- To reduce demand on GP Primary Care (and potentially A&E attendances, admissions and readmissions to hospital for persons referred into the service) by improving their health and wellbeing.
- To improve the health and wellbeing of individuals
- To help improve the quality of life of individuals through education and low level support
- To enable individuals to develop friendships and networks
- To raise individuals awareness of available services
- **We utilise our Business Intelligence and analytical expertise to identify areas of need**, whether that is people with high numbers of A&E attendances and emergency admissions, areas of the city with specific condition prevalence, or to identify trends in activity.
- Persons are **identified through a number of routes but primarily between the GP and Community Matron utilising a Risk Stratification tool. Once identified the person is contacted to obtain consent for the Multi-Disciplinary team to case manage them.** (Multi-Disciplinary teams are made up of Community Matrons, District Nurses, Social Workers, Specialist nurses and link with the Persons GP, community mental health teams and voluntary sector when appropriate). **The person is then referred onto the MDT caseload where a joint (health and social care) plan is agreed and implemented.**
- **GPs will now also be identifying and monitoring the persons Frailty index** and these persons will also be case managed to reduce the risks associated with frailty.
- Now the **Fibonacci system (electronic shared record) has been successfully implemented across health and social care, it is used within the MDT environment to look at the person record** and can also be utilised by members of the team when they are with the person to ensure that they have the most up to date person information.
- **A robust Telecare offer has been created to support users to remain in their own homes and communities**, through the provision of technology based on individual needs and, where appropriate, provision of mobile response to a non-injury fall or instance of no response from the user, as provided by West Midlands Fire Service (WMFS). In 16/17 there were 2,219 response callouts, 57% relating to a fall, and only 14% of all callouts resulting in an ambulance intervention. Telecare is currently provided to over 5,000 people across the city, with a growth objective of 3,000 new users over a 3 year period through to end of 18/19. 2016/17 saw 1,150 new users supported. The development of the Telecare offer aims to support:
  - Reducing admissions due to falls
  - Rapid Hospital Discharges/Delayed Transfer of Care
  - Reduce, defer and delay the need for more intensive support
  - Reduced spend on delivery of care services both in care homes and at home
  - Meeting needs of an ageing population with reducing budgets
  - Promoting independence and self-management in the citizens of Wolverhampton

An example of the partnership with WMFS and the approach across Health and Social Care can be seen at: <https://www.theguardian.com/healthcare-network/2017/apr/27/firefighter-falls-callout-service-easing-pressure-ambulances>

- **For Dementia:-**
  - Using the pathway in the Joint Dementia Strategy the Memory Matters project has been developed to respond to a need for information advice and guidance to support early diagnosis.
  - Multi agency dementia awareness training is now being rolled out
  - The care market is being incentivised to support people with dementia

- A revised commissioning model for clinical services has been commissioned that responds to the NICE guidelines

### 5.3 Reactive Approach

- Whilst much resource is aligned to managing people's conditions and preventing an acute crisis, some people will, at some time experience an exacerbation of their condition, either with their physical or mental health. We have implemented and continue to enhance a number of rapid response elements to the programme to further avoid emergency admissions to those persons in crisis

#### 5.3.1 Mental Health Street Triage

- The mental health street triage care is a service jointly provided by CWC, BCPFT, WMAS and West Midlands Police. It is imperative that people with mental health problems get the right assessment, care and treatment they need as quickly as possible especially in emergency situations. This arrangement sees mental health nurses accompany officers to incidents where police believe people need immediate mental health support. The aim is to ensure that people get the medical attention they need as quickly as possible, thus preventing inappropriate use of police custody cells & and s136 suites
- Please see below link for media coverage of the Street Triage work and evidence of the Social Value of this way of working

<https://www.expressandstar.com/news/2017/05/19/black-country-triage-team-save-west-midlands-police-18m/#9AkYSmbseulSb5Sg.03>

#### 5.3.2 Community Rapid Intervention Team

- The purpose of the team is to **primarily prevent unnecessary hospital admission by providing a multi-disciplinary team approach for those experiencing an acute episode of illness or injury who are in a health and/or social care crisis.** See Figure 14, p28 – Example of the co-designed integrated pathway for the Rapid intervention Teams (RiTs)
- Once the acute episode of care has been managed, **the service will then work with a wide range of health, social care and voluntary sector professionals to identify and agree the on-going management of the persons** and the requirements of the person and carer, to be able to confidently manage their condition (where clinically appropriate) within their usual place of residence.
- The service will have the **following locally defined outcomes:**
  - A progressive reduction in attendances at A&E and all urgent care portals
  - A progressive reduction in emergency admissions to acute based care
  - A progressive reduction in preventable admissions
  - A progressive reduction in readmissions for persons within a 90 day period
  - Incremental increases in improvement in person experience
  - All referrals will be responded to within the agreed timescales
  - Delivery of care in the persons home or usual place of residence
  - A comprehensive assessment of the health and social care needs of each person
  - A progressive reduction in the delayed transfers of care for persons fulfilling the criteria for this service
  - Support timely discharge from hospital
  - Improvement in recovery from the acute episode of their illness
  - Maximise independent, healthy living and build confidence to enable persons to self-care
  - Utilise equipment including Telecare and telemedicine to enhance and support independence

- Working with Social care partners, prevent admissions to permanent nursing or residential care
- Working with Social care partners, prevent the need for high intensity social care packages of care
- Provide step up care to persons to avoid admissions to hospital
- Work in partnership with other agencies to provide a seamless service to all persons

Figure 14 – Co-designed integrated pathway for the Rapid intervention Teams (RITs)

**Service**

- Nurse Led Rapid Intervention Service supported by a Medical Consultant
- The service provides assessment, diagnostics and treatment to patients at risk of hospital admission.
- Operating Hours 8am-8pm daily

**Objectives**

- Avoidance of unnecessary hospital admissions
- Safe management of acute health conditions in the patients home environment

**Criteria**

- Adults aged 18 or over
- Wolverhampton resident and/or registered with a Wolverhampton GP
- Patients who are at risk of admission to hospital. For example, patients with:
  - Suspected infections e.g. Chest infection, Urine infection and Cellulitis
  - Exacerbation of long a term conditions e.g. COPD and Heart Failure
  - Suspected faecal impaction
  - Rapid deterioration in functional ability (due to acute illness or injury) requiring fast track intervention by physiotherapy and/or Occupational Therapy.

*\*Please note, the above list is not exhaustive. For advice regarding other potentially appropriate referrals, please contact the team on the advice line below.*

**Exclusions**

- Continuing fits, lasting more than 5 minutes
- Residents who are too unstable to wait for assessment – 999 required
- Falls/head injuries with loss of consciousness
- Minor illnesses or conditions which would not result in a hospital admission and that could wait for a routine GP visit

To make a referral telephone  
**01902 443322**  
 Monday-Friday 8am-6pm  
 Saturday-Sunday 9am-3pm  
 All referrals will be triaged and an appropriately trained clinician will aim to assess the patient within 2 hours of referral  
 For advice only 07769 565757

The Wolverhampton Better Care Programme consists of many partners across the city. These include: Wolverhampton Clinical Commissioning Group, The Royal Wolverhampton NHS Trust, City of Wolverhampton Council and Black Country Partnership NHS Trust

### 5.3.3 Reablement

- **The Bradley Reablement service** provides a short term residential reablement programme to enable a person's timely discharge from hospital, assessment of needs in a community environment, enable further recovery, encourage independence and facilitate a return to independent living at home as early as possible. The service has access to on site therapists and social care staff and referrals are made to equipment, Telecare and community based services where required to ensure a coordinated approach to returning home. Referrals are also received from the community for short term work to aid a person's return to on-going independence at home.
- **The Home Assisted Reablement Programme (HARP) Reablement service** provides a short term reablement programme in an individual's home, working together with the person and

appropriate partners to maximise skills, independence and confidence to ensure on-going independent living at home. The programme supports people to be as independent as possible ensuring individuals continue with activities associated with daily living skills, personal care, kitchen skills, mobility skills and social inclusion. The HARP service will promote awareness and use of assistive equipment and technology to maintain a person's independence, reduce dependency on support services and promote safety within their home environment. The service receives people by way of hospital discharge or community referrals.

#### 5.3.4 Evidence Based Approach

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- **Integration is the key to delivering demonstrable improvements in quality, value and outcomes for the people of Wolverhampton.** There are a significant number of emerging case studies and papers which support the case for integrating services.
- **The case for developing integrated, person-centred services and the benefits to be derived from this is clearly articulated in the Kings Funds 'Making Best Use of the BCF' and "Making Our Health and Care Systems Fit for an Aging Population",** the 9 components of which have been absorbed into Wolverhampton's planning.
- Evidence suggests implementing integrated care has shown that integrated health and social care services can support older people to maintain their independence longer. **This helps to prevent emergency admissions, reduces length of stay in hospital and as a result reduces demand on full social care, all core areas of focus in Wolverhampton.**
- **There is a strong emerging evidence base for the BCF plans and Wolverhampton is confident that by building on current and previous experiences, it can embed and deliver sustainable, resilient and responsive integrated services that are person-centred.** A recent example of this is the delivery of integrated discharge planning services, and the mutual benefits derived from them. There are also a number of case studies available from the schemes that are now up and running with a sample included at [Section 6.1, p37](#) that evidence the impact on the individuals and their families.
- Articulating what is meant by integration is equally important in supporting the case for change. **Wolverhampton has undertaken significant consultation, local evidence review and engagement prior to selecting the 5 work stream programmes that it proposes to take forward between now and 2020.** A summary of these is included at [Section 2.4, p6](#), *Figure 1* with more detail in *Appendices 1 and 2*
- **Workshops have been held across the health and social care economy** with stakeholders across all areas, professions, providers and communities. **There have been public events for people and their carer's to talk about their experience of local community** as well as through GP locality events with our primary care providers.
- Themes have emerged that have become golden threads in the description of the **need to deliver integrated, person-centred services**, in short Wolverhampton' services:-
  - **Must be more explicit and coordinated across health and social care** in the targeting of resources, thereby removing the traditional boundaries in existence. **People only want to tell their story once.**
  - **Must be sustainable, resilient and able to deliver better outcomes,** quality and value through behavioural and organisational change.
  - **Must strengthen the way community and primary care facing services are constructed and delivered** in order to reduce the growing pressures on the local emergency and urgent care systems
  - **Must maximise the value of return on investment** through activity shifts from hospital to community facing services as a means of **Page 105** realising benefits

- **Must ‘upstream’ the focus toward asset based local community developments** for a redesigned model of integrated delivery of community facing services
- **Must encourage through design, living well, self-care, self-management and maximisation of choice**
- **The outcome of this process has been the identification of core work streams whose focus will be on transformational service redesign** that works towards the vision, outcomes and ‘end state’ as described and visualised in [Section 2, p4](#). In doing so Wolverhampton has laid down the marker for its level of ambition and commitment to deriving maximum benefit from the BCF Programme.
- The core work streams are outlined in the table below, alongside the national and local evidence base for their inclusion in the programme;

Workstream	Evidence Base
<b>Adult Community Care</b>	Stepping up to the Place – NHS Confederation The Evidence Base for Integrated care – The Kings fund Delivering better services for people with long-term conditions - Building the house of care. The Kings Fund The Torbay Model – “Mrs Smith” Building bridges, breaking barriers, Care Quality Commission Making our Health & Care systems fir for an ageing population, The Kings Fund Efficiency opportunities through health & social care integration, Local Government assc Supporting integration through new roles working across boundaries, The Kings Fund Integrated care for older people with frailty – Royal College of General practitioners
<b>Mental Health</b>	The Five Year Forward View for Mental Health (NHS England) Bringing together physical and mental health” (March 2016), The Kings Fund No Health Without Mental Health Case Study: Sandwell Nurse Led Psychiatric Liaison
<b>Dementia</b>	JCPMH: Practical Mental health Commissioning - Dementia LGA Integrated Care Value Toolkit Dementia Map NICE Dementia Care Pathway – Dementia Interventions NICE Dementia Care Pathway - Diagram and Assessment NICE Dementia Care pathway - Overview
<b>CAMHS</b>	Future in Mind: Children and Young People’s Mental Wellbeing (Department of Health/NHS England) Transforming Care Plan (The Black Country) Wolverhampton CCG CAMHS Transformation Plan What good could look like in integrated psychological services for children, young people and their families What really matters in children and young people’s mental health Implementing the five year forward view for mental health

## 6. Reflection on 2016-17

The workstreams and projects within them were outlined in our plan for 2016/17. The table below demonstrates our progress and achievements against those projects.

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Workstream	Project	Aims and Objectives	Measurable Outcomes	BCF Policy Framework National Conditions
<b>Adult Community Care</b>	<b>The Continuing development of three locality based Integrated Health and Social Care Community</b>	Working with partners to develop a Wolverhampton City Strategy to deliver the vision of the BCF ACC workstream. To ensure that our planning of services takes account of the opportunities to provide truly	Reduction of A&E attendances  Reduction of emergency admissions	Jointly agreed plans Supporting 7 day services Better data sharing Joint approach to care planning and

	<p><b>Neighbourhood Teams, wrapped around Primary Care and supported by specialist teams and Voluntary Sector</b></p>	<p>integrated care to our local population by wrapping services around our persons to deliver person centred, holistic care. To ensure we are commissioning services based on evidence of need including the complexity of conditions our population is presenting with. To continue to build good working relationships with our providers, co-producing services based on the holistic needs of the population working towards commissioning for outcomes. Providing both proactive and rapid response to our person's needs. Development of extensive Community Offer reducing demand on health and social care services and supporting citizens to become more independent</p>	<p>Reduce DToC</p> <p>Improve person experience</p> <p>Co-location of the H&amp;S care teams</p> <p>Reduction in high cost demand by 5%</p>	<p>assessments</p> <p>Agreement on the consequential impact on providers</p> <p>Investing in out of hospital services</p> <p>Supporting plans for reducing delayed transfers of care</p>	
<p><b>Achievements / Current Situation</b></p> <p><b>Joint working:</b> The Community nursing teams and Social care colleagues now meet in each locality on a monthly basis for an integrated MDT supported by a newly developed electronic IT solution to capture individual care plans. This year has seen the introduction of mental health into the MDT and the work stream.</p> <p><b>Admission Avoidance:</b> The admission avoidance team have commenced seven day working and continue to work in partnership with Primary Care, WMAS, Voluntary sector and the Local Authority reablement services avoiding admissions and conveyances to accident and emergency.</p> <p><b>Step up beds:</b> The CCG has commissioned a small number of step up beds to pilot the impact on avoidable admissions. This pilot will be fully evaluated to measure the impact in terms of quality of person care and impact on emergency admissions.</p> <p><b>Discharge to Assess (D2A):</b> This year has seen the introduction of a major programme of work on delayed discharges. Senior responsible officer for the programme is the Lead for Adult Social Care supported by the CCG Head of individual care. The programme has representatives from health and social care including our main acute care provider to ensure a whole system approach and the scope focuses on pathway redesign to promote and embed a 'home first' approach to hospital discharge.</p> <p>The main objectives of the programme are:</p> <ul style="list-style-type: none"> <li>• support admission avoidance where appropriate</li> <li>• support timely discharge from hospital</li> <li>• maintain independence wherever possible</li> <li>• reduce the level of long term packages of care</li> <li>• have a net neutral impact on the health and social care economy</li> <li>• provide a 7 day service</li> </ul> <p><b>Fibonacci:</b> This year saw the successful implementation of an electronic shared care record. This initiative supports the monthly integrated MDT's. Phase 2 will commence in May and this will bring online Mental Health and Primary Care.</p> <p><b>Reablement:</b> <b>Telecare</b> - is offered by the City of Wolverhampton Council and supports people to live independently in their own homes by giving them a range of assistive technology, from emergency alarms and fall detectors to smoke and flood sensors. It aims to give peace of mind and reassurance 24 hours a day to people who are either living on their own or caring for someone else by providing support in crisis situations.</p>					
	<p><b>The Development of a Wound Care pathway</b></p>	<p>To provide a seamless 7 day service for persons who will receive treatment at the right time, in the right place by an appropriate health</p>	<p>New Wound Care pathway</p> <p>Improved person experience</p>	<p>Jointly agreed plans</p> <p>Supporting 7 day services</p> <p>Better data sharing</p>	

		professional	Efficiencies in reducing variance  Standardisation of assessment for non-healing wounds	Agreement on the consequential impact on providers Investing in out of hospital services	
	<p><b>Achievements / Current Situation</b></p> <p>A multi stakeholder steering group has fully reviewed the current ambulatory wound care provision across Wolverhampton. This has included Primary Care, Community Care and domiciliary care. Some pathways within the acute hospital have also been reviewed to provide a more whole system approach. A new model of care has been developed to include a robust whole pathway approach including prevention and education that will deliver an optimal service for our population. The new model is a community based model with a clinical streaming element to ensure persons are treated by staff with appropriate capacity and capability. The model has a number of outcomes including quality of life outcomes for this person cohort.</p> <p>We need to agree for community services the 7 day services e.g. weekend increase for DN to provide a 7 day service as only essential needs are met. Community Matron now 5 days how do we build this model and consider 7 day service around self-activation of PMP and support</p>				
<b>Workstream</b>	<b>Project</b>	<b>Aims and Objectives</b>	<b>Measurable Outcomes</b>	<b>BCF Policy Framework National Conditions</b>	
<b>Dementia</b>	<b>The development of a Dementia Hub for Wolverhampton</b>	The aim is to promote greater independence and choice for people with dementia, increasing their self-esteem and encouraging people to maintain good social and personal relationships. Amongst other things the hub model would host an Integrated dementia team, a Dementia Café, the Education and Awareness programme and the Dementia Pathfinders	A detailed specification for the hub and what it will provide.	Jointly agreed plans Supporting 7 day services Investing in out of hospital services Agreement on the consequential impact on providers	
	<b>Raising Awareness, information advice and guidance</b>	The aim of this project is to ensure that all citizens and professionals have a relevant understand of dementia and can find information easily when required	Increase the number of people who are Dementia Friends Wolverhampton maintains its 'working towards being a dementia friendly community	Jointly agreed plans	
	<b>Memory Matters clinics</b>	This is a community based 'pop up' information and advice service run by health and social care professionals (CPN/SW/CDWO) offered in a non-health and social care venue on the first Tuesday of every month across a twelve month period. The aim is to provide information and to signpost people towards support and early diagnostic services where appropriate  The project received funds from The Big Lottery to co-produce information for the public. Co-production was undertaken with young people and people from BME groups	Reduced anxiety around memory concerns  Family carers re more confident about supporting a relative to seek diagnosis  Increasing awareness of dementia and how to support someone with dementia	Jointly agreed plans	
	<b>Dementia Care pathway</b>	• To 'pump prime' service transformation by increasing	Analyse of HRG data and cluster	Jointly agreed plans Better data sharing	



		<p>number of dedicated liaison and outreach dementia staff across RWT and by increasing the remit of their role to pro-actively assess and navigate the required next steps for patients with dementia or suspected dementia presenting in RWT.</p> <ul style="list-style-type: none"> <li>To align dementia care pathways across the 'whole system' across primary, secondary and tertiary care including residential and nursing care to improve care, clinical outcomes and quality of life from diagnosis to end of life and where possible, reduce unplanned admissions to RWT and BCPFT.</li> </ul> <p>All of the above provide an opportunity to develop and deliver a transformational plan</p>	<p>data within BCPFT to identify admission causes for those with primary or secondary diagnosis dementia to inform service redesign. Dedicated PMO support will scope and describe current care pathways against best practice including NICE Guidance</p> <p>Reduce relapse, hospital admissions to RWT, numbers of people placed out of Wolverhampton in acute overspill and / or longer stay beds by keeping people well and responding pro-actively to periods of relapse / crisis.</p>	<p>Agreement on the consequential impact on providers Investing in out of hospital services</p>	
<p><b>Achievements / Current Situation</b></p> <p><b>Joint Working</b> The group has established a strong ethos of joint working across CWC, CCG RWT BCPFT, carer services and the Dementia Action Alliance. The DAA is the local partnership board where representative from voluntary, community, and retail organisations work collaboratively to make Wolverhampton a dementia friendly community. The involvement of the DAA in the BCF programme ensures that the pathway re-design is co-produced at a number of levels.</p> <p><b>Dementia Awareness</b></p> <ul style="list-style-type: none"> <li>BCPFT have trained all staff in dementia awareness at a level that is appropriate for the job they have</li> <li>Dementia is mandatory training at CWC</li> <li>The Dementia Action Alliance has been re-launched</li> <li>Alzheimer's Society did a dementia awareness session at the Team W event for GP's</li> </ul> <p><b>Memory Matters</b> The first six sessions were centrally located and well attended but the service now moves around the city and pops up at relevant locations to rotate the sessions. Dates and venue are being published on WIN. Feedback to date indicates that the local people place a high value on receiving quality, informed and accurate information about concerns for their own or someone else's memory functions. The service is being formally evaluated with a view to moving from its current 'pilot' status into a permanent service</p> <p><b>Dementia Hub</b> The new model and the business case are still in development. The BCF group have agreed to review the business case and undertake some research into other models of dementia hubs. The alternative models will include satellite surgeries in existing community resources. Professionals and members of the Dementia Action Alliance (DAA) are involved in developing the specification through feedback at the DAA. The dementia hub and alternative model will be included in the consultation plan and the final model will be developed following consultation in December 2017.</p> <p><b>Dementia Care Pathway</b> Pathway agreed as specified in the Joint Dementia Strategy which improved access to specialist services, improved early diagnosis and more staff appropriately trained in dementia. Next steps are to develop the pathway to include all services available in each element of the pathway and to publish information in a single portal – probably utilising WIN</p>					
<b>Workstream</b>	<b>Project</b>	<b>Aims and Objectives</b>	<b>Measurable Outcomes</b>	<b>BCF Policy Framework National Conditions</b>	

<b>Mental Health</b>	<b>Street Triage</b>	The MH Rapid Response Triage care is a dedicated "blue light" ambulance vehicle deployed under guidance of Police / AMBO control rooms. It delivers a 7 day multi-agency response (Police, Ambulance and CPN) to appropriate 999 and 111 calls across the Black Country population of 1.2million. Planning is underway to further develop the service through the inclusion of AMHP expertise Expanded as per 15/16 service redesign and in 16/17 to include focus on dementia.	Options appraisal for inclusion of AMHP into rapid response car developed.	Jointly agreed plans Support of 7 day services Better data sharing Investing in out of hospital services.
	<b>Hospital Discharge Pilot</b>	Hospital Discharge pilot to include re-focus in 16/17 on Penn and RWT delays Dedicated social care mental health support to urgent care pathway to increase the number of AMHPs and provide dedicated support to Penn Hospital to reduce delayed discharges and facilitate mental health in patient flows with RWT and BCPFT.	Achievement of 7 day access to urgent health and social care services	Jointly agreed plans Support of 7 day services Better data sharing Supporting plans for reducing DTOC.
	<b>Mental Health Liaison Psychiatry</b>	Service expanded as per 15/16 service re-design and in 16/17 to include re-focus on dementia	Achievement of 7 day access to urgent health and social care services	Jointly agreed plans Support of 7 day services Better data sharing
	<b>Reablement and 1st Avenue</b>	This will involve the implementation of a redesigned recovery and outreach service that includes:- Provision of a 2 bed crisis unit Integrated reablement / outreach recovery pathway An assertive outreach service Community recovery service – provides assertive outreach approach for people with moderate to severe mental health difficulties to provide early diagnosis and commencement of treatment pathway to ensure and maintain recovery and prevent episodes of crisis and / or relapse and readmission delivered from a range of bio-medico – psycho interventions, fully utilising NICE guidance	Operational 2 bed crisis unit in the community Operational social care assertive outreach service	Jointly agreed plans Support of 7 day services
	<b>Resettlement</b>	A two tier approach that will include:- The timely identification of individual needs through health and social care assessment and case review activity The development and implementation of additional supported living (50 units over a 3 year period) The development and implementation of a single floating support service	Operational access to 26 additional supported living units Integrated reablement / outreach recovery pathway	Jointly agreed plans Support of 7 day services Better data sharing Supporting plans for reducing DTOC.
	<b>Prevention</b>	This will involve the recommissioning via tender	Commissioned single joint	Jointly agreed plans Investing in out of

		process of a single joint prevention service across health and social care	prevention service	hospital services
	<b>Urgent Care Pathway</b>	Delivers Wolverhampton Crisis Concordat for adults of all ages with a focus on compassionate and practice and responsive services and interventions, including starter schemes initiated in 2015/16 described above and also including single Point of Access and crisis resolution and Home treatment fully utilising NICE guidance	Redesign, develop implementation of interoperational implementation plan across AMHS and dementia Achievement of 7 day access to urgent health and social care services.	Jointly agreed plans Support of 7 day services Better data sharing Investing in out of hospital services
	<b>Community Recovery Service</b>	Provides Assertive outreach approach for people with moderate to severe mental health difficulties to provide early diagnosis and commencement of treatment pathway to ensure and maintain recovery and prevent episodes of crisis and /or relapse and readmission delivered from a range of bio-medico – psycho interventions, fully utilising NICE guidance	Redesign, develop implementation of interoperational implementation plan across AMHS and dementia	Jointly agreed plans Support of 7 day services Better data sharing Supporting plans for reducing DTOC. Investing in out of hospital services
	<p><b>Achievements / Current Situation</b></p> <p><b>Street Triage:</b> Discussions were held with Street Triage about the possibility of an AMHP being included into the car, however this was not considered necessary by stakeholders who believed this was an unnecessary use of resource.</p> <p><b>Hospital Discharge Pilot:</b> This pilot began in June 2016 and information was provided to the A&amp;E board in February 2017 to evidence that the aims and outcomes were met. This resulted in an extension to this pilot for another 12 months. This is currently being fulfilled by an Experienced Social Worker/ AMHP who is seconded from the MH Social Work Team (Mon-Fri).</p> <p><b>Reablement and First Avenue:</b> Provision of 2 bed crisis unit achieved through a contract with P3. Social care ‘assertive outreach’ type service in place to support prevent crisis and promote independence and community inclusion for service users.</p> <p><b>Resettlement:</b> Social care case review completed and assessments on-going to support service users in moving to less restrictive environments, and therefore promoting independent living and community inclusion. 14 flat scheme (Woodhayes) projected to be completed in July 2017.</p> <p><b>Prevention:</b> Service with a prevention focus commissioned by LA called ‘Starfish’ and commenced April 2017. Further work is required to map and review all preventative services and to redesign, respecify and potentially re-procure on a city wide basis. This is reflected in our 2017/19 plan. Our mental wellbeing needs assessment has been completed and this will inform service development.</p> <p>Mental health colleagues are now invited to the Community MDT that takes place in each locality when mental health input is required.</p>			
<b>Workstream</b>	<b>Project</b>	<b>Aims and Objectives</b>	<b>Measurable Outcomes</b>	<b>BCF Policy Framework National Conditions</b>

<b>CAMHS</b>	<b>Transformation of CAMHS services</b>	This work stream is to be included in the Programme for 16/17 in "shadow form". It will utilise the governance and joint working approach of the programme to deliver a review and transformational change of CAMHS services across Wolverhampton. The programme manager leading on this piece of work is a joint appointment between the CCG and Local Authority	An assessment and review of current CAMHS services. A transition plan of redesign of CAMHS services	Jointly agreed plans
	<b>Achievements / Current Situation</b>			
	Following a review of the CAMHS services it has been identified that the main gap is the tier 2 services. Funding has been identified from WCCG and CWC to procure a service to meet these needs. These services to be managed under the BCF with a section 75 completed for a pooled budget to be agreed.			
<b>Workstream</b>	<b>Project</b>	<b>Aims and Objectives</b>	<b>Measurable Outcomes</b>	<b>BCF Policy Framework National Conditions</b>
<b>Integration</b>	<b>Estates</b>	To identify estates requirements for the programme as a whole and for individual projects. For example to support the co-location of Community neighbourhood teams, the moving of outpatient clinics from an acute to community setting, the development of a dementia hub and of developing dementia services in the community. To work with Estates colleagues to scope appropriate premises and to work towards the move to integrated health and social care teams	Estates specification produced Premises identified	Jointly agreed plans Supporting 7 day services Joint approach to care planning and assessments Agreement on the consequential impact on providers Investing in out of hospital services Supporting plans for reducing delayed transfers of care
	<b>IT</b>	To implement the Fibonacci system to enable health and social care staff to share information on a role-based access view only basis. To continue the exploration of open APIs for the economy with a long term view of developing integrated health and social care systems	Fibonacci implemented Integrated Health and Social Care record	Jointly agreed plans Better data sharing Joint approach to care planning and assessments Supporting plans for reducing delayed transfers of care
	<b>IG</b>	To ensure that pathways, processes and systems have robust and appropriate information sharing agreements at all stages and comply with Caldicott 2	Signed Data Sharing Agreement	Jointly agreed plans Better data sharing Joint approach to care planning and assessments Supporting plans for reducing delayed transfers of care
	<b>HR</b>	To ensure that in the move toward integration and the changes in person and service user pathways that change management processes are undertaken appropriately and fairly and all relevant policies and legislation is adhered to		Jointly agreed plans Supporting 7 day services Joint approach to care planning and assessments Investing in out of hospital services
	<b>Achievements / Current Situation</b>			
	<b>Estates</b> - Work continues to progress in finding suitable accommodation for the co-location of Integrated Health and Social care teams and for the provision of services in the community. Whilst it has proved difficult to find suitable premises all key stakeholders are still committed to driving this forward. The Local Authority and CCG are jointly funding a Consultant to undertake a Service Strategy and Feasibility studies on potential estate across the City. This strategy will take into consideration the direction of travel in Primary Care and also work being undertaken within the STP.			

**IT** – We have successfully implemented an IT system “Fibonacci” that pulls health and social care data into one view for members of the Community multi-disciplinary team. This enables front line staff to manage persons more effectively understanding all of the contacts and interventions that the person has undergone, relevant to their care management. The system is co-commissioned by CCG/LA/RWT/BCPFT. We continue, through the Local Digital Roadmap Group to explore options for an Integrated H&SC record and for systems to provide H&S care data to holistically inform our commissioning decisions.

**IG** – we have a Data Sharing Agreement in place covering the functions of the BCF programme which is signed by CCG/LA/RWT/BCPFT ensuring our compliance with Caldicott 2.

**HR** – HR is a standing agenda item at the Integration Workstream. This enables us to identify any HR issues that may arise in relation to the integration of teams or Co-location etc.

## 6.1 Case Studies

### CASE STUDY 1

#### Admission Avoidance - Rapid Intervention Team

##### The Scenario...

*96 year old lady, referred by her GP. GP treated this lady with oral antibiotic with no improvement and had been bedbound for over a week. Her daughter was out of the country on holiday and the lady refused to go into hospital...*

##### What we did...

Specialist Nurse Practitioners from the **Rapid Intervention Team** completed a full health assessment and diagnosed an unresolved Chest Infection. The dose of Antibiotics was increased, Community Intermediate Care Team nurse working within rapid response were contacted and **visits were made on a daily basis to encourage mobility, independence, ensure medication was given and also ensure adequate dietary intake.**

##### The Outcome...

**Person able to stay safely within own home and a hospital admission was avoided.**

##### Person said...

*“We received all of the help we had hoped for when the new service was mentioned. We cannot stress how valuable the help and support that was given by the rapid response team. We were able to receive treatment at home and remain out of hospital”.*

## CASE STUDY 2

### Reablement - Telecare

#### The Scenario...

Couple signed up for Telecare after husband suffered a stroke which left the 83 year old with weakness in his left arm, mobility problems and susceptible to falls.

#### What Telecare did...

Each time a fall was reported the fire service came out to help him back onto his feet. They also checked him over to make sure he wasn't injured, and carried out a Safe and Well check with the couple on their home. **Each time, the presence of the mobile response service avoided the need to call an ambulance**

#### The Outcome...

**Person able to stay safely within own home and a hospital admission was avoided.**

#### Couple said...

"The Telecare service is such a reassurance. The fire service is able to help me up when I have a fall and carry out a thorough check to make sure I'm okay, and it's a big relief to know I can get help".  
"Everyone in Wolverhampton should know about this valuable service. It gives us freedom and provides our family the peace of mind that, if something does go wrong, we will be able to get the support we need."

## CASE STUDY 3

### Risk Stratification/Case Management

#### The Scenario...

Retired 67 year old gentleman was referred to Community Matrons via a local GP for management of his social conditions in relation to his alcoholic dementia. Patient is also a smoker. His Risk Stratification score was low. This was because the gentleman had not had any recent hospital admissions and so he wasn't registering on the electronic system as a high risk. **On the initial assessment by the Community Matrons there were several issues identified:**

- Lives alone and only has support of his ex-wife
- Had many episodes of forgetfulness.
- Had only had x 3 baths in a year.
- Had previously had a house fire
- Sleeping on sofa, hadn't been to bed for years
- Not taking any medications despite dementia diagnosis and blood pressure problems.
- Had extremely dry skin on his feet, unkempt nails (not washing)

#### What we did...

Referral to the Fire Brigade who performed a home visit and installed smoke alarms and provided full 'fire retardant' bed linen. The Matrons have helped to get a care company in after years of patient refusing help. The care company are from his multi-cultural background and he now really engages with them. He now has a weekly shower, has help with his cleaning (they encourage him) and they will take him out weekly for a walk, shopping etc. The Matrons also referred person to podiatry (chiropody) for foot health. The Matrons have worked closely with the GPs and have prescribed some medication for his blood pressure and requested some cream for his legs and feet. The Matrons have helped person to find a way to remember to take his tablets and his blood pressure is now a greatly improved. The Matrons and the GP are slowly considering medication to help with his alcoholism. They have made a referral to Telecare to request a Pivotal medication system (medication reminder machine) and a personal alarm in case he has a fall at home.

#### The Outcome...

**Person received community based person centred support to prevent hospital admission**

## CASE STUDY 4

### Admission Avoidance - Rapid Intervention Team

#### The Scenario...

Person taken ill in the night and too unwell to go to GP next morning. Husband went to local practice and the receptionist referred to Rapid Intervention Team (RiTS)...

#### What we did...

Within the hour a nurse arrived at the house, took her temperature (38.9) and her oxygen level which was very low. The nurse got patient to use her inhaler a few times and ensured she was using it properly, she explained that this was to increase her oxygen levels and open up her airways. She was also advised to open a window, take off the bedcover and sleep with just a sheet at night until her temperature was under control. The RiTS Nurse prescribed antibiotics and took sputum samples. From then on she had daily visits from the nurse from the Community Nursing Team who checked her temperature and oxygen levels. 5 days later a matron arrived who had the results from the tests and patient was diagnosed with Lung disease: Bronchiestis Pseudomonas – Aeruginosa (bacterial infection). Further medication was prescribed by the Rapid Intervention Nurse

#### The Outcome...

**Person received care at home for 2 weeks and was discharged under the care of the community**

#### Person feedback was...

*"Very grateful and impressed with the quick response and wonderful service from both agencies, because it takes the worry out of being ill, it was wonderful to be at home in comfort and in the care of her husband and the health teams" Described the nurse as "a ray of sunshine"*

## CASE STUDY 5

### Mental Health - Resettlement

#### The Scenario...

Individual aged 30 lived in a rehabilitation nursing home with 24 hour support for over 12 years. Had diagnosis of Schizophrenia Disorder and a speech impairment which made it very difficult for people to understand them. Clinically obese due to on-going poor eating habits and would drink 6 litres of fizzy pop per day. Weight condition impacted on physical health causing high blood pressure and cholesterol levels as well as breathing difficulties and sleep apnoea. Person lacked motivation and did not engage in any social activities, requiring 24 hour support to prompt and assist in all areas of daily living and did not participate in any physical activity. Sometimes they would display challenging behaviours and intimidate other people as well as self-harm.

#### What we did...

Social worker visited to complete an assessment of needs along with family, advocate and care provider. Everyone involved in the assessment felt person would benefit from living in a supported living scheme where they could develop independence, motivation and daily living skills. It was agreed that a culturally sensitive scheme would be beneficial and social worker identified an option. Individual and brother went to have a look at the scheme and both liked it there. Person supported by the outreach team to purchase my furniture and to move in. Staff supported to enable the person to overcome intial nerves around the move and helped them to develop a routine including support attend the day centre for lunch.

#### The Outcome...

Now been living in new home for 3 months, **preparing and cooking own healthy meals and snacks** with support from staff. **Socialises with the other tenants** who are all supportive. Gets on well with staff and developed a good sense of humour. **Laughs a lot and has not become upset or self-harmed.** Now **walks independently** to and from the day centre every day which is approximately 1 mile, attends a football session and a hearing voices group once a week. **Lost 4 stone and breathing, blood pressure and speech impairment have all improved.**

## CASE STUDY 6

### Mental Health – Resettlement (2)

#### The Scenario...

Individual aged 30 living in a nursing home for over 25 years - had never lived alone. All meals were prepared & cooked for person and staff in the nursing did laundry and cleaned bedroom. Suffers from chronic anxiety, OCD, an eating disorder and schizophrenia.

#### What we did...

Introduced person to social worker and advocate who both supported through the assessment process. They both worked with person to find out what they enjoyed to do, what they were good at and what the person needed help with. New places were visited, went out for lunch and the person was taught how to cook new things including making a shopping list and subsequent shopping for the ingredients. Social worker and cousin took person to look at lots of different houses and they chose their favourite which was in a very sheltered housing scheme. They were able to attend the day centre at the housing scheme before moving in to help them to get to know the staff and residents

#### The Outcome...

Person has been living in their new home for 3 months now, getting help and support from the staff to cook their own meals and do laundry. Person is able to do their own cleaning but sometimes need reminding. They go shopping with the social care worker and chooses what they want to buy for meals. They go out most days and have learnt to know their way around their new community. Person visits cousin and she often now comes to their house too along with other friends and neighbours they have made.

#### Family said...

*"I would like to thank you very much for the excellent way you have handled the recent resettlement of my cousin. I hope that many more will have the pleasure of your dedicated work to enable them to move forwards with confidence and happiness"*

## CASE STUDY 7

### Dementia – Memory Matters

#### The Scenario...

Mother and daughter attended Memory Matters session at the Local Library. Daughter was finding it difficult to approach the subject of her mother's memory for fear of upsetting her. Daughter felt mother was in denial of the extent that her memory was declining and mother would get very upset if it was mentioned and refused to get any help.

#### What Memory Matters did...

The Community Support Officer discussed memory decline which provided daughter (carer) the opportunity to voice her concerns to her mother. Mother admitted that she had tried to conceal her memory loss through fear of diagnosis and to prevent relatives from worrying, however it was a relief to get it out in the open.

Mother was encouraged to attend GP Surgery for a physical health screening and to talk about memory loss. Social activities were also suggested to keep her mind active and to increase her support network to reduce social isolation. Information leaflets were provided for Mother to read at her own leisure and to remain in control regarding choices going forward.

Daughter was provided with Carers assessment information.

#### The Outcome...

**Mother chose to attend the GP surgery supported by her daughter. She also attends local activities to keep her mind active and to reduce isolation.**

#### Feedback received...

*Carer " It was such a relief to be able to talk openly, to have someone to listen and to feel supported was very helpful, I'm hopeful that my mom will attend the surgery to have her memory looked into, Thank you for all your help"*

*Mother "I didn't realise the upset I was causing my daughter the friendly lady made it easy for me to admit I have been forgetting things quite a lot, I didn't feel judged made to feel I was going mad. With my daughters support I will attend the GP Surgery and the social group"*



## 7. 2017-19 Plan

Workstream	Project	Aims and Objectives	Measurable Outcomes	BCF Policy Framework National Conditions (New and Maintaining Progress)
Adult Community Care	People living with Frailty Programme	Review and redesign of current pathways to ensure services are meeting the needs of our aging population. A revised model of care will place a stronger focus on prevention, aging well with the delivery of proactive care aiming to keep people living independently for longer.	<ul style="list-style-type: none"> <li>• Gap Analysis working with NHS Right Care to inform direction</li> <li>• Define scope and plan for redesign based on gap analysis and best practice</li> <li>• Pilot Frailty Clinic in Primary Care (developed through Primary Care Home Model aligning to the new GP contract requirements)</li> <li>• Delivery of Prevention services, aging well agenda and proactive care</li> </ul>	<p><b>Plans to be jointly agreed, Agreement to invest in NHS commissioned out of hospital services which may include 7 day services and adult social care, Managing Transfers of Care, Supporting 7-day services, Better data sharing between health and social care, based on NHS number, 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, Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans</b></p>
	Review and Redesign of community services programme	<p>In depth review of current Community Based services to establish effectiveness, efficiency and improve quality.</p> <p>To adopt a place based approach to the delivery of community based services ensuring where possible, persons are activated and encouraged to self-manage and remain in their usual place of residence where appropriate.</p> <p>Undertake a scoping exercise to identify acute based services that could safely be delivered within a community setting to achieve care closer to home</p> <p>Co-production of detailed plan and the development of a robust business case based on opportunities identified</p>	<ul style="list-style-type: none"> <li>• Full review of current services with recommendations and or options for redesign and or improvement</li> <li>• Implement new model of Ambulatory Wound care across the city</li> <li>• Analysis of acute based services that could potentially transfer</li> <li>• Options Appraisal and Business Case</li> <li>• Plan for implementation</li> <li>• Governance documents – Quality impact assessment, equality impact assessment, privacy impact assessment</li> </ul>	
	Discharge to Assess Programme	This important programme of work is underway and working at pace to redesign pathways out of hospital to ensure a 'home first' culture is adopted and embedded when discharging persons from acute care. Workstreams have been identified, with named leads and project plans developed.	<ul style="list-style-type: none"> <li>• Pilot and roll out across agencies of trusted assessor model</li> <li>• Pilot and roll out of D2A Hub</li> <li>• Redesign/Commission/ Procure new services to facilitate new pathways</li> <li>• Reduction in DTOC monitored and delivered</li> </ul>	
	Admission Avoidance Programme	Review and development of established Admission Avoidance capability to identify opportunities to improve current performance and further promote services to partners and stakeholders.	<ul style="list-style-type: none"> <li>• Fully implement 7 day working across admission avoidance teams</li> <li>• Continue to work in partnership with Primary Care and other</li> </ul>	

15,  
16, 11

11

			Undertake modelling with Primary Care to ensure alignment with new models of care emerging across the City	<p>professionals delivering proactive care to persons identified through risk stratification</p> <ul style="list-style-type: none"> <li>• Embed and further develop MDT across localities utilising electronic shared care record</li> <li>• Develop plan for further partnership working with West Midlands Ambulance Service (WMAS)</li> <li>• Evaluate Step up bed pilot and seek approval to roll out.</li> <li>• Development of robust business case for step up beds based on outcome of evaluation</li> <li>• Further roll out of redesigned CICT service</li> </ul>		
<b>Workstream</b>	<b>Project</b>	<b>Aims and Objectives</b>	<b>Measurable Outcomes</b>	<b>BCF Policy Framework National Conditions (New and Maintaining Progress)</b>		
<b>Dementia</b>	<b>Refresh of the Joint Dementia Strategy</b>	Clear direction of travel. Vision for dementia services in Wolverhampton	<p>Dementia strategy signed by all key stakeholders with implementation plan – integrated approach (including an Integrated Care Pathway) involving Primary Care, Mental Health and Acute and Community Services</p> <p>A stakeholder mapping event with CCG, RWHT and social care professionals took place in April. A revised model with commissioning intentions is being developed. The revised model will be consulted on and take to health scrutiny – consultation to be completed by Dec 17.</p>	<p><b>Plans to be jointly agreed, Agreement to invest in NHS commissioned out of hospital services which may include 7 day services and adult social care, Managing Transfers of Care, Supporting 7-day services, Better data sharing between health and social care, based on NHS number, 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, Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans</b></p>		
	<b>Establishment of permanent Memory Matters service</b>	The service has been extended and is now a roaming clinic to ensure the service is reaching a wider audience Public health are completing an evaluation to support the establishment of permanent service.	<p>Permanent service established, dementia awareness increased, increase in early diagnosis of people with dementia.</p> <p>Outreach Dementia Tool development to continue</p>			
	<b>Explore the potential Re-commissioning of Dementia Cafes</b>	The aim of this project is to establish a well-functioning dementia café service that supports people with dementia and their family	<p>Review of current service to be completed in June 17, this will include focus groups</p> <p>New specification developed by August 17</p>			

			commence in September with a new provider in place for April 1st 18	
	<b>Dementia Awareness Training</b>	To develop a city wide multi agency training and awareness plan to increase awareness of dementia and support Wolverhampton becoming a dementia friendly community where all staff have appropriate dementia awareness training	Training Plan agreed by all key stakeholders with implementation plan	
	<b>Dementia Hub to remain within the scope of work stream</b>	Clear Vision and model for Dementia Hub is developed, consulted on and agreed	Service Specification signed by all key stakeholders with implementation plan	
	<b>Dementia – Mental Health Liaison to become part of Core 24</b>	As per CCG Operational Plan / NHS E Planning Guidance collaborative model across Acute and Mental Health Trust (pilot currently in place – focus on reduced non-elective admissions, greater support to nursing / residential care and reductions in hospital lengths of stay)	Service Specification signed by all key stakeholders with implementation plan	
	<b>Day Care Opportunities</b>	As per CCG / BCPFT SDIP and Operational Plan / NHS E Planning focus on NICE Evidence based care pathways for patients clusters 18-21 and also a focus on reduced non-elective admissions, greater support to nursing / residential care and reductions in hospital lengths of stay	Service Specification signed by all key stakeholders with implementation plan  A review of Blakenhall has commenced.	
<b>Workstream</b>	<b>Project</b>	<b>Aims and Objectives</b>	<b>Measurable Outcomes</b>	<b>BCF Policy Framework National Conditions (New and Maintaining Progress)</b>
<b>Mental Health</b>	<b>Review of Preventative Services</b>	Identify and develop joint commissioning/integration opportunities that exist that may prevent escalation into more complex/acute services	<ul style="list-style-type: none"> <li>• Cohort analysis</li> <li>• Map of current as is preventative services in Wolverhampton (including community and voluntary sector)</li> <li>• Gap Analysis</li> <li>• Produce business case for joint commissioning Intentions</li> <li>• Awareness of available services and how to access them</li> </ul>	<b>Plans to be jointly agreed, Agreement to invest in NHS commissioned out of hospital services which may include 7 day services and adult social care, Managing Transfers of Care, Supporting 7-day services, Better data sharing between health and social care, based on NHS number, 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, Agreement on the consequential impact of changes</b>
	<b>Mapping of Current Services and Pathways</b>	To map out all current pathways and services for Mental Health in Wolverhampton	<ul style="list-style-type: none"> <li>• Cohort analysis</li> <li>• Map of current as is Pathways in Wolverhampton</li> <li>• Gap Analysis</li> <li>• Produce business case for joint commissioning Intentions/Options for new Pathways if appropriate</li> <li>• Awareness of available services and how to access them</li> </ul>	
	<b>Review and</b>	To review current Discharge	• Review / evaluation of	

		<b>Development of Discharge Planning and Pathways</b>	policies / pathways and to produce an agreed Discharge pathway for patients with mental health needs	current discharge policies to include review of assessment and discharge planning under care planning approach (CPA) <ul style="list-style-type: none"> <li>• Policy (Section 117) agreed and Procedure developed and signed off</li> <li>• Toolkit and Pathway developed and implemented</li> <li>• Alignment with the D2A Project</li> <li>• Evaluate Penn Hospital Discharge Pilot</li> <li>• KPIs developed</li> </ul>	on the providers that are predicted to be substantially affected by the plans
		<b>Develop New Model of Integrated Mental Health Services/Offer in Wolverhampton</b>	To identify and co-design opportunities for greater integration across partners	<ul style="list-style-type: none"> <li>• Workshop to develop ideas and document what good integration would look like and benefits</li> <li>• Options appraisal and business case</li> <li>• Implementation Plan</li> </ul>	
		<b>Co-existing Mental Health, Alcohol and Substance Misuse</b>	Development of a project to identify and manage high service users of Acute hospital services, a significant number of which have dependencies upon alcohol and substance misuse.	<ul style="list-style-type: none"> <li>• Data Sharing Agreement finalised and approved</li> <li>• Project developed / Business case development</li> <li>• Implementation plan</li> </ul>	
		<b>Urgent Mental Health Care Pathway</b>	Refresh CRISIS CONCORDAT. Continued focus on reduction of non-elective admissions to RWT for high volume service users.	<ul style="list-style-type: none"> <li>• Review current Concordat</li> <li>• Refresh as appropriate</li> </ul>	
		<b>Mental Health Assertive Outreach Service</b>	Review the requirement /gaps for a MH Assertive outreach service	<ul style="list-style-type: none"> <li>• Gaps in service identified.</li> <li>• Options paper for Mental Health Assertive Outreach Service produced</li> </ul>	
<b>Workstream</b>	<b>Project</b>	<b>Aims and Objectives</b>	<b>Measurable Outcomes</b>	<b>BCF Policy Framework National Conditions (New and Maintaining Progress)</b>	
<b>CAMHS</b>	<b>Transformation of CAMHS Service</b>	Following a review of the CAMHS services it has been identified that the main gap is the tier 2 services. Funding has been identified from WCCG and CWC to procure a service to meet these needs. These services to be managed under the BCF with a section 75 completed for a pooled budget to be agreed.	Procurement of a suitable tier 2 service which reduces the number of referrals being sent through to specialist CAMHS. <ul style="list-style-type: none"> <li>• <b>Emotional Health &amp; Wellbeing</b> project scoping, gap analysis, service specification and procurement</li> <li>• <b>Workforce Development</b> project scoping, gap analysis, skill mix audit, training and implementation plan</li> <li>• <b>CAMHS pathways</b></li> </ul>	<b>Plans jointly agreed</b>	

			<p>project scoping, insight/research, gap analysis, stakeholder engagement and development of project plan</p> <ul style="list-style-type: none"> <li>• <b>System sustainability</b> resource mapping/report, implementation plan and schools provision framework</li> </ul>		
<b>Workstream</b>	<b>Project</b>	<b>Aims and Objectives</b>	<b>Measurable Outcomes</b>	<b>BCF Policy Framework National Conditions (New and Maintaining Progress)</b>	
<b>Integration</b>	<b>Estates</b>	<p>Identify and commission premises for integrated health and social care teams (Community Neighbourhood Teams) in the short term to allow more effective integrated working. 3 locality based teams</p> <p>Develop a service strategy to determine which services will be delivered in the community in which areas. This will influence the estates requirements</p> <p>Identify and undertake feasibility studies for premises for Community Neighbourhood hubs based on the needs identified in the Service Strategy.</p> <p>Identify Funding and commission Community Neighbourhood Hubs</p>	<p>Teams co-located in each of the 3 localities</p> <p>Wolverhampton wide Service Strategy produced</p> <p>Locations/premises identified</p> <p>Feasibility Studies produced</p> <p>Hubs operational</p>	<p><b>Plans to be jointly agreed, Agreement to invest in NHS commissioned out of hospital services which may include 7 day services and adult social care, Managing Transfers of Care, Supporting 7-day services, Better data sharing between health and social care, based on NHS number, 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, Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans</b></p>	
	<b>IT</b>	<p>Expand use of Fibonacci to Mental Health data and explore option of including Primary Care data</p> <p>Identification of a system to enable Integrated Health and Social Care record</p> <p>Agreement on a common system/s to provide secondary data to inform commissioning decisions</p>	<p>Mental Health data available in the system.</p> <p>Primary Care data available in the system</p> <p>System identified</p> <p>System/s commissioned</p>		
	<b>IG</b>	<p>Ensure the Data sharing Agreement is fit for purpose during the evolution of the BCF Programme</p>	<p>Regular reviews and updates to DSA are undertaken</p>		
	<b>Communications and Engagement</b>	<p>Co-production events, jointly presented LA and CCG to work with public, persons and carers</p> <p>Development of a Communication and Engagement Plan for 2017-19</p> <p>Internet/Intranet, Newsletters, GP Briefings updated regularly</p>	<p>Events planned and undertaken</p> <p>Revised Communication and Engagement plan in place</p> <p>Regular Updates</p>		
	<b>Developing joint</b>	<p>Develop a plan to further</p>	<p>Options appraisal</p>		

	<b>commissioning</b>	integrate staff across health and social care, either virtually or co located.	produced for collaborative commissioning/joint commissioning posts in the future
	<b>HR</b>	As the programme moves towards further integration and co-location of health and social care staff, and the moving of clinics from and acute setting into the community, ensure that HR issues are identified and addressed in a timely manner	HR involvement in Integration and Co-location plans

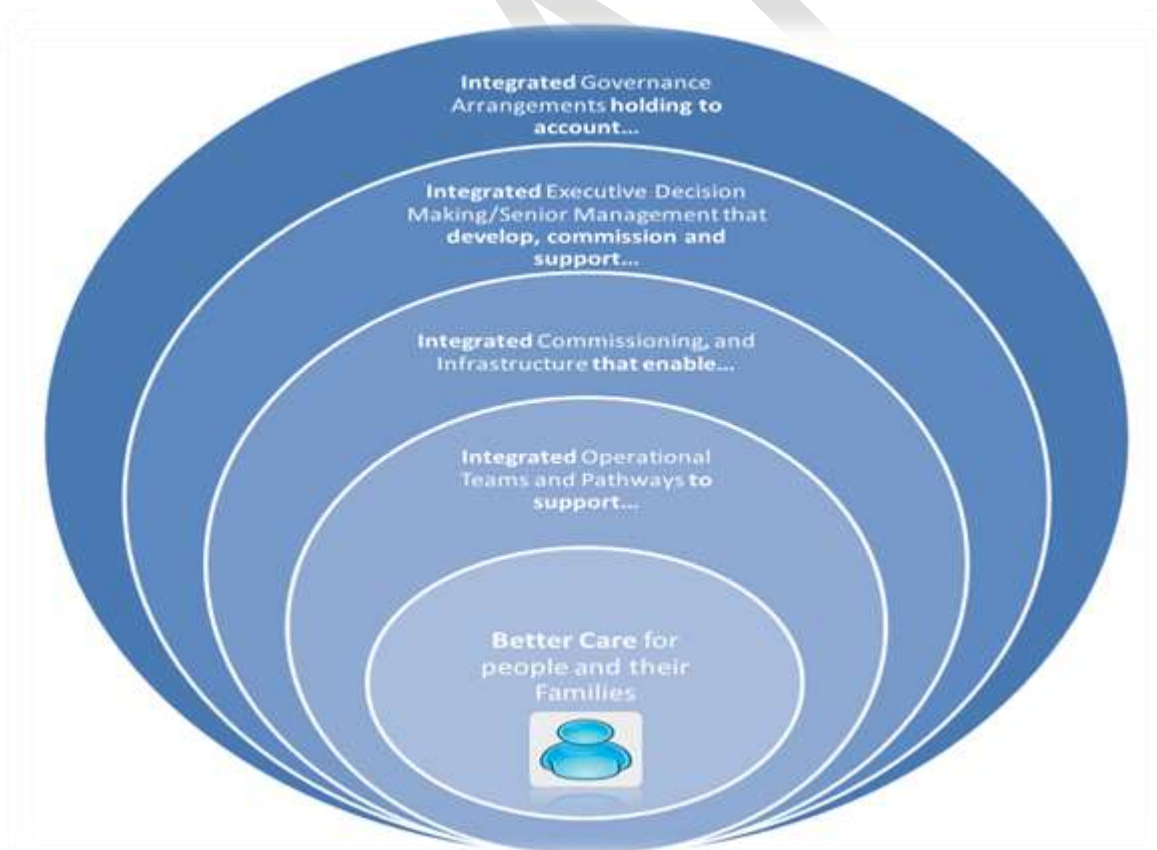
## 8. Integration

### 8.1 Our Vision and Model for Integration

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- Wolverhampton’s model of integration is based on the principle where individuals and organisations in the city work together, creating joined up care around individuals and their family’s needs. This model of working is underpinned by the development of strong partnership governance arrangements that holds executive management across our organisational boundaries to account, as well as the continual building of integrated functions such as data sharing, information technology (e.g. Fibonacci), commissioning and the genuine co-design of new pathways and services. A summary of this model is included in *Figure 15* below

*Figure 15 – Wolverhampton’s Summary Model of Integration*



- This model is being brought to life across health and care in Wolverhampton and some specific examples follow:-

### 8.2 Integrated Governance Arrangements

#### 8.2.1 Section 75

- The Better Care Fund has been established by the Government to provide funds to local areas

to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose.

- Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.
- The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also means through which the Partners will be able to pool funds and align budgets as agreed between the Partners.

### 8.2.2 Integrated Programme Structure

- The Better Care Fund Programme Structure demonstrates an integrated programme structure both in the PMO (*see figure 12, p20*) and in the Workstream structure. Each Workstream within the programme has a lead nominated from CCG, CWC and Provider organisation. These leads work together, to deliver the objectives of the work stream, redesigning pathways and in an integrated way. One example of a new integrated pathway co-designed by the Adult Community Care Workstream can be demonstrated in *Figure 14, p28*.
- Each workstream meets on a fortnightly basis and consists of members from the three key organisations (CCG, CWC, Provider) and other key stakeholders. *See Appendix 10* for an example of a Terms of Reference.

## 8.3 Integrated Executive Decision Making and Senior Management

### 8.3.1 Wolverhampton Transition Board

- Recognising the continued pace of change across the local health and social care economy, Wolverhampton CCG, The Royal Wolverhampton Trust, Black Country Partnership NHS Foundation Trust and the City of Wolverhampton Council have established a Transition Board. The Transition Board is made up of Executive leaders from across each organisation and acts as a joint forum to support system transformation across Wolverhampton to ensure that it delivers better health outcomes for residents across the city. Their vision statement is: *'To promote health and wellbeing for the Wolverhampton community, enabling them to live longer and healthier lives.'*
- The Transition Board will be responsible for setting the strategic direction for system transformation across the City and for making recommendations to the constituent organisations about actions to be taken to ensure transformation work helps to achieve the overall vision in the City's Joint Health and Wellbeing Strategy, Ensuring good health and a longer life for all in Wolverhampton.
- The board is working towards the following principles:-
  - Ensure the health and care needs of the people of Wolverhampton are at the heart of everything we do
  - See the whole person, recognising and respecting their life experience and views
  - Support people to receive care closer to home, improving the system so that hospital is the last resort
  - Be open and honest with the community and each other, about what we can achieve and what we cannot, and ensure we deliver what we promise
  - Work together locally and nationally, removing barriers to make people's use of services

simpler and a more positive experience

- o Make Wolverhampton a great place to work in and maintain a quality sustainable workforce, fit for the future

### 8.3.2 Senior Responsible Officers (SROs)

- Each work stream within the programme is allocated an SRO as lead for the workstream. The SRO provides strategic direction and guidance for the work stream and reports highlights, risks and escalations to the Programme Board for their workstream. SROs are Executive level within their organisations and as such have the authority to make decisions and unblock issues at the most senior level.

## 8.4 Integrated Commissioning and Infrastructure

### 8.4.1 Joint Quality Assurance of Care Homes – Quality Nurse Advisor Team

- The Joint Quality assurance of care homes is undertaken by the Quality Nurse Advisors (CCG) and the Quality Assurance and Compliance Officers (CWC). **This integrated way of working aims to provide assurance that the care delivered in Care Homes is safe, high quality, effective and responsive to the needs of the individual.** The Quality Nurse Advisors assess care delivery by carrying out quality monitoring visits and analysing data received from care homes on the national safety thermometer and the monthly quality indicator submissions and involvement in conducting pressure ulcer root cause analysis investigations and supporting homes with implementing quality improvements and training. Information sharing is fundamental to promoting harm free care and best practice in Care Homes, and there are close working relationships with Regulatory Bodies, Partner Organisations and Statutory Agencies with the aim to reduce unnecessary hospital admissions by preventing avoidable serious incidents and enabling effective management of chronic conditions. **The integrated work programme includes:-**

Objective	Benefits/Outcomes
Revision of quality assurance visit tool for care homes	Collaboratively standardise the approach to quality assurance and compliance and develop a suite of reporting documents/best practice tools
Development of an on-line self-assessment tool for care homes and providers	Collaboratively standardise the approach to quality assurance and compliance and develop a suite of reporting documents/best practice tools
Development of a Risk Matrix for care homes	Standardise approach to quality assurance & compliance
Joint quality and sustained improvement visits	Standardise approach to quality assurance & compliance Universal approach to Quality Assurance and Compliance processes for the provider/care home and good customer experience for the service user/patient
Provide Health and Social Care support to facilitate management of failing Providers under LA Large-Scale Strategy	Collaborative approach to managing failing providers
3 Yearly Care Home/Domiciliary Registered Care Managers Development Events	Collaborative approach to developing care home managers Build good intelligence and rapport with Providers/care Homes Deliver three - six workshops in 2017/18 to improve quality of care
Provide health advice and investigations to MASH (Multiagency Adult Safeguarding Hub)	Collaborative approach to adult safeguarding providing daily clinical expert advice.
Co-chair CQC information sharing	Collaborative approach to adult safeguarding
Joint working for Pressure injury and falls prevention	Citywide approach to prevention of major harms The aim of the Scaling Up Improvement project is to introduce a tool that improves the prevention &



#### 8.4.2 Communication, Engagement and Marketing

- Within the BCF Programme there is a dedicated Communications and Engagement lead that represents the four key partner organisations. Wolverhampton CCG's Communications, Engagement and Marketing team undertakes this role and regularly works with both commissioning and provider communications teams on a variety of both long and short term projects.
- Communication leads from Wolverhampton CCG, City of Wolverhampton Council, The Royal Wolverhampton NHS Trust and Black Country Partnership NHS Foundation Trust meet face to face at 6-8 week intervals, with a standing agenda item of Better Care Wolverhampton. As the agenda includes other areas such as STP, safeguarding, and city wide campaigns there is assurance that the communication around BCF is aligned with other Wolverhampton priorities.
- Both telephone and email contact is regular between these meetings and covers any joint press releases, such as the launch of the Fibonacci software. See link below for example of our integrated approach to press releases:-

<https://wolverhamptonccg.nhs.uk/news/320-wolverhampton-patients-benefit-from-pioneering-technology>

- Not just targeting the general public and persons, all leads for communications share communications for use within existing internal channels and membership groups, to share information about integrated working and innovation within both their own organisations and those that they work closely with. Working jointly through sharing of local knowledge allows us greater flexibility within our limited resources.

#### 8.4.3 Estates

- Estates are managed within the BCF via the Integration work stream which also includes Finance, Performance and IT. There are existing forums with their own terms of reference where collaborative estates strategic (Local Estates Forum (LEF)) and operational (CCG Capital Review Group (CRG)) work is carried out. There is representation from the Local Authority, the CCG, RWT and BCPFT at the LEF, supported by Community Health Partnerships (CHP) who also support the One Public Estate (OPE) work streams. At the CRG the lead is taken from the LEF and operational plans are discussed and actioned by operational managers from all organisations, including the BCF Programme leads.

#### 8.4.4 Integrated Commissioning

- With the support of the BCF and the pooled budget we aim to jointly commission services where we can jointly influence service provision and make efficiencies both financially and in relation to service improvement and user experience. Examples of these are:-

##### Community Equipment Service

- The CWC and the CCG are commissioning an **integrated community equipment service** to meet health and social care needs across the City. One of the key strategic objectives is that care is delivered closer to home and that services are designed and commissioned in recognition of people's desire to remain at home.
- The overarching intention is to help all people maintain as much control over their lives as possible and to promote their independence, health and wellbeing. Equipment can make a

fundamental contribution to this agenda and can bring significant benefits to both social care and health partners, by:

- Enabling all people to live in the community for longer
- Reducing the need for and the level of domiciliary care packages
- Reducing care home and avoidable hospital admissions
- Facilitating early discharge from acute care
- Reducing the amount of time people, including children and young people spend avoidably in hospital through better and more integrated care in the community
- Supporting persons approaching end of life to die in their preferred place of death

## CAMHS

- The transformation of the emotional mental health and wellbeing service system involved the establishment of the CAMHS Transformation Partnership Board (CTPB). A place based care model has been co-designed with partners, and aligns with the establishment of Strengthening Family Hubs and HeadStart satellite sites. These co-located, multidisciplinary teams will be able to deliver care closer to home, as well as devise specific proactive interventions targeted to meet the needs of the neighbourhoods in which they work.
- The budgets for children and young people's Emotional Mental Health and Wellbeing service were managed in shadow form by the Better Care Programme Board during 2016/17. Some of the Mental health services for children and young people which are funded both by Wolverhampton CCG and City of Wolverhampton Council are proposed to be governed through joint arrangements with Wolverhampton Clinical Commissioning Group (WCCG) and City of Wolverhampton Council (CWC), and in a similar manner to adult mental health services. This will result in a joint approach to commissioning, contract management, and activity monitoring for this service. Further, by joining budgets for services that are funded by both CWC and WCCG, Emotional Mental Health and Wellbeing services can be more effectively aligned.

### 8.4.5 Local Digital Roadmap

- **The Wolverhampton Local digital roadmap was developed via a cooperative process between Health and Social Care organisations** that provide services within Wolverhampton. This plan is now incorporated within the Black Country Local Digital Roadmap. The key areas of development within Wolverhampton are:
- **Sharing information across sectors of care:** The development of a shared care record across the whole Health and Social Care economy, which will include primary, secondary, community, acute, mental health and Social Care. The CCG are deploying EMIS Remote consultation and mobile access to Clinical systems, enabling GP practices to utilise mobile working and access to patient records across primary care.
- **Empowerment:** The rollout of patient online services, allowing patients to access their own records, book appointments, view test results, letters and order repeat prescriptions. The expansion of e-referrals to social care and inclusion of child protection information within unscheduled care settings.

### 8.4.6 Joint Approach to Provider Failure

- There is a diverse market for care and support services in Wolverhampton including public, private and voluntary sector organisations. As in any market, some providers leave whilst new providers come in. Providers may leave the market for a number of reasons; examples include a provider selling on its property for residential use or a provider's business being taken over by a competitor. Most exits from the market are handled responsibly by providers who ensure that those receiving care services continue to do so in line with contractual obligations. This process is

normally managed in an orderly way that does not cause disruption of services for the people receiving care. Occasionally, when care providers do exit the market in a way that adversely impacts on their ability to manage the closure of the service in a planned way, the agreed Provider Failure Policy is initiated. These procedures give clear guidelines on how any failures can be mitigated and managed to minimise the risk to people who use our services. In all circumstances a coordinated response between the Local Authority, Wolverhampton CCG, and the care provider will be required. The CCG are a key stakeholder, their critical role is to work as part of the strategy group, review any clients who are funded by the CCG, take any relevant actions and respond within the timescales agreed by the strategy group. The CCG are also invaluable partners when assessing risk to residents and advising on clinical responses to these risks. **A close collaborative relationship between the LA and CCG supports effective management of provider failure and supports a holistic approach to supporting the residents affected.**

## 8.5 Integrated Operational Teams and Pathways

### 8.5.1 Mental Health

- **Adult Mental Health are considering options for progressing an integrated service** as part of the Better Care fund recommendations for improved service delivery.
- **Street Triage** – The mental health street triage care is a service jointly provided by CWC, BCPFT, WMAS and West Midlands Police. The service aims to ensure people with mental health issues are kept out of police custody and receive the right treatment and care. The service is mental health nurses and paramedics accompanying police officers where it is believed people need immediate mental health support.
- **Psychiatric Liaison** – Integration in as much as the team (? Who are they?) are embedded within ED at RWT

### 8.5.2 Integrated Health and Social Care Team

- The team operates an integrated set of functions across health and social care, incorporating patient flow, social work and community care assessment with administrative and management support wrapped around. They operate in a collaborative way that promotes communication and maximises the opportunity for effective discharge planning with appropriate outcomes using the following philosophy:-
  - To provide support and advice across the range of specialties within the Acute Trust and Step Down facilities.
  - Ensure that the patient/family receive the appropriate outcomes, providing information and support on services that they can access and promote choice and inclusion in their planning for discharge.
  - Provide additional, expert support as Health and Social Care Practitioners, interfacing between agencies to ensure that client receives the right support at the right time and in the right place.
  - To begin planning for discharge as early as possible to identify complex issues and ensure effective discharge arrangements in line with the medical plan for discharge including starting from pre-admission clinics.

### 8.5.3 Multi-Disciplinary Teams

- There are three locality based multi-disciplinary teams across Wolverhampton. They include Community Matrons, District nursing, social workers and therapists. Specialist teams such as heart failure nurses, palliative care consultants, community mental health teams, Home

Improvement team or the patients GP are opted onto the MDT to discuss specific patients. The MDT is supported by a consultant geriatrician and the purpose of the meetings is to manage patients with complex needs in the community by care co-ordination and joint care planning.

## 9. Alignment with Sustainability and Transformation Plan (STP)

- We are fully aware of the interdependencies between BCF and the STP. Links across both programmes of work are maintained from SRO, Programme Management and Workstream lead level. In Wolverhampton, wherever possible we utilise the BCF Programme Structure as the vehicle for the Place Based STP delivery. For example the review of Community Services and determining of services to be delivered in primary and community care is managed through the BCF Adult Community Care workstream. This then informs the development of the Wolverhampton STP place based model. Our work stream lead for Mental Health is also the STP mental health lead for the Black Country and therefore the two programmes of work are aligned with any duplication or contradiction identified at the earliest stage. The current Black Country Sustainability and Transformation Plan, is included in *Appendix 10*.

## 10. National Conditions

### 10.1 National Condition 1 – Plans to be Jointly Agreed

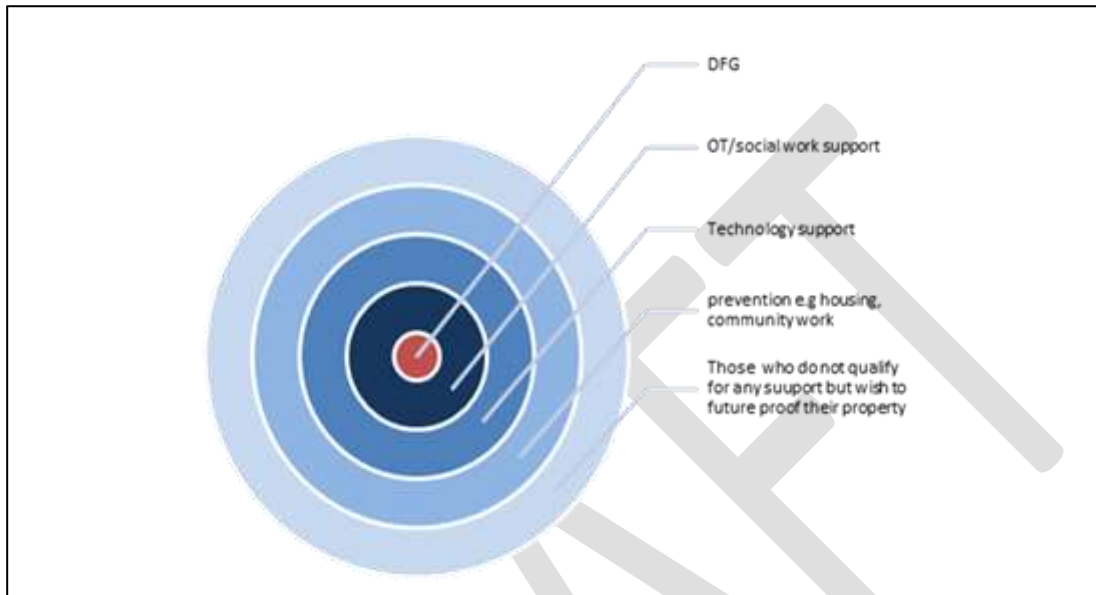
- Wolverhampton local health & social care economy is wholly committed to improving the health and wellbeing of its people. The principle of co-production is fully supported by the BCF partner organisations and is embedded in the overall governance structure of the programme. In 2016-17 partners agreed a set of principles about what the content of the pooled fund / BCF Programme should support and this agreement continues through to the 2017-19 plans. The principles are:-
  - Co-production
  - Better Health Outcomes
  - Improved Well- Being
  - Promoting Independence
  - Identifying and utilising inter-dependencies between organisations
  - Moving intervention downstream
  - Targeted interventions by integrated teams
  - Working with Voluntary Sector
  - Care Closer to home
- The DFG budget sits within the housing capital programme for CWC (which is a single tier authority) and is included in the Pooled Fund ([See Section 4.6, p23](#)). The plan for spending the DFG monies is currently as per mandatory requirements and the existing discretionary policies (these support fast track installation of ramps and stair lifts).
- Equipment and adaptations are a key enabler to maintaining independence and CWC will work in partnership with stakeholders to consider future actions required in delivering DFG's and adaptations. Colleagues from CW have been invited onto the BCF workstreams where appropriate and discussions are on-going around the shaping of further housing contribution to the current and future BCF plans including the potential for the co-design of a new DFG pathway. *Figure 16* below represents the current high level model for housing support in Wolverhampton through from prevention to the greatest of need (the DFG). BCF plans to explore opportunities that may exist across all of the tiers to enhance current and future plans

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Figure 16 – CWC Model for Housing Support



- There is currently no official submission deadline for the 2017/19 plan but colleagues across partners are working proactively in line with the Policy Framework and latest Regional advice to produce a plan that will be a solid foundation upon which to amend quickly once official guidance is available.
- To mitigate against this ‘delegated authority sign off’ has been agreed by the CCG Governing Body on 11<sup>th</sup> April 17. The plan will then need to be presented to LA Senior Executive Board (SEB) on xxx for internal approval and will be presented to the Chair of the Health and Wellbeing Board \*\*\* and cabinet lead for Adult services on xxx, and the cabinet lead for children and young people on xx. Arrangements for formal acceptance and agreement of the BCF plan and content of the pooled budget are as follows:-
  - CCG Governing Body May 2017.
  - Health and Well Being Board 28<sup>th</sup> June 2017. Delegated Authority (Cllr Lawrence, Chair of Health and Well Being Board) for sign off prior to submission.

**10.1.1 Involvement of stakeholders**

- Through the CCG Clinical Reference Group, the plan has had oversight and input from Primary Care Colleagues. The Plan has also been shared with A&E Delivery Board, Health watch and Wolverhampton Voluntary Sector Council. Routine, regular, focused BCF meetings with the chair of the H&WB Board, other key elected members of the local council and the CCG Governing Body (made up of member elected GPs from each of the localities) have taken place throughout the duration of the programme and each body continues to approve and sign off planning at each stage of the implementation process.
- In the period prior to each submission phase, the development of the BCF plan (co-produced with work stream leads) is discussed with the Senior Responsible Officers and the BCF

Programme Board each month. Executive representation from Health and Social Care providers (RWT, BCPFT and CWC) are full members of this BCF Programme Board. In addition, the Programme is supported by work stream groups (led by commissioning leads) who are proactive in the planning and development of transformation plans. These work stream groups include operational managers from across Wolverhampton's health and social care commissioner/provider services.

- This co-production of transformation planning and implementation from strategic to operational ensures that all partners are cognisant of what the re-designed service will look like in the future and as a result, what the predicted impacts of changes to service delivery will be. This approach is supported within health by discussions within the contract negotiation process which details the activity that will be impacted at HRG level and within social care through the established review monitoring and negotiation processes.
- In terms of wider stakeholders, Wolverhampton has always and continues to engage with stakeholders:-
- Design phase events included over 120 frontline Health and Social Care local professionals, individuals, users, carers, voluntary sector organisations and community groups.
- Engagement with the public has demonstrated that people want care closer to home.
- With regard to impacts for the voluntary sector, current grant recipients and other agencies are invited on a regular basis to the work streams to promote services, facilitate discussions and identify opportunities for closer working relationships. There is a Voluntary Sector forum that is held quarterly and is managed by the voluntary sector council. The LA and CCG attend the forum with a view to supporting VS organisations in capacity building (how to tender, financial stability, assistance with grant applications).
- The Local Authority is currently developing its community offer in conjunction with its stakeholders. Its aim is to provide an effective, targeted community offer, which helps citizens remain healthy, happy and independent for longer, and in so doing reduce, delay or prevent the social care needs of citizens. This is a key enabler of other projects looking to promote independence and reduce costs because it provides alternative support options. One element currently provided is the Social Prescribing pilot, which works a number of GP practices offering low level support regarding benefits, finance, housing etc. freeing up GP's time to deal with appropriate appointments. Wolverhampton Voluntary Sector Council (WVSC) are also running a 12 month pilot for Social Prescribing to support people with low level needs with the aim of improving people's wellbeing and reducing social isolation.

## 10.2 National Condition 2 – NHS contribution to Adult Social Care is maintained in line with inflation

- CWC Cabinet Report of 26/4/2017 (*see Appendix 11*)
- The minimum CCG contribution for 2017/18 is £18.182m and £18.527m for 2018/19 which includes £964k (**note: still awaiting figure for 2017-18 £964 represents last years as a guide only**) Care Act monies and is in line with CCG overall budget inflation as notified by NHSE. The CCG can confirm that this minimum contribution is maintained and exceeded with the total CCG contribution being £37.865m. The development of integrated health and social care pathways and teams, including adult social care continues to be a priority within the programme, ensuring that there is no detrimental effect on the local health and social care system. *See Planning Template for detail.*
- Agreement on the high level plans for the allocation of IBCF money to ensure the local social care provider market has been attained.
- The Wolverhampton vision (see [Section 2, p4](#)) and delivery model ([Section 5, p24](#)) outline the

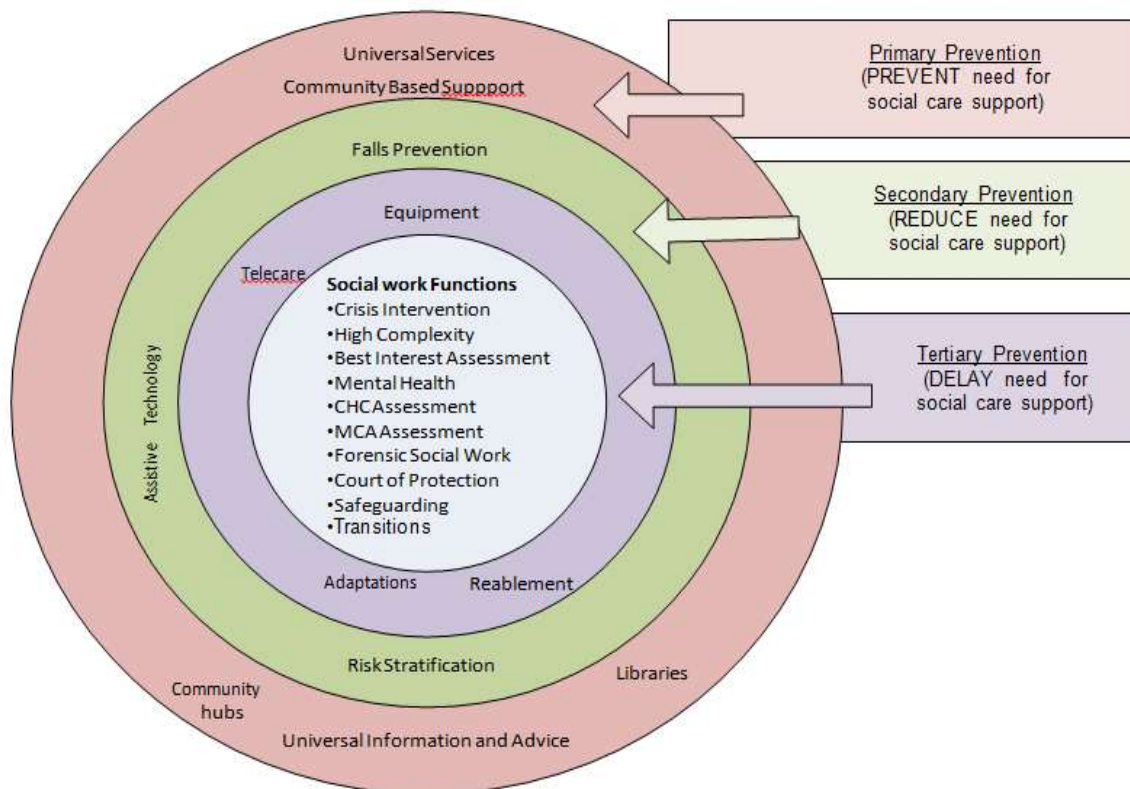
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plans for transforming and integrating the health and social care landscape in Wolverhampton and articulate the benefits, both in health and otherwise, to the population with the specific outcomes listed in [Section 2.4, p5](#). The sample of case studies included at [Section 6.1, p37](#) outline how the BCF schemes are benefiting the people of Wolverhampton now.

- The following protection of social care model (*Figure 17*) continues to be adopted across the BCF work streams, recognising that protection of social care is a key BCF objective.

Figure 17 - Protection of Social Care Model



### 10.3 National Condition 3 – Agreement to Invest in NHS commissioned out of hospital services, which may include 7 day services and adult social care

• **NOTE – awaiting planning guidance around the minimum allocation for NHS commissioned out of hospital services.**

- The projects within the BCF Programme all support the movement of activity from acute to community, primary, social care, voluntary and general preventative services. An example is the work between GP’s and community matrons to risk stratify people who are then case managed by the integrated health and social care teams and the development of the Community Rapid Intervention Team (see [Delivery Model, Section 5, p24 for details](#))
- Risk stratification tool is currently being used which enables Community Matrons to work with GPs to identify patients at high risk of emergency attendance/admission. Individualised care management plans are developed for these patients with a view to managing their condition more proactively and reduce their risk of future health deterioration, maintaining people in the community. We continue to work with partners to redesign these proactive pathways with the ambition to move activity from secondary care to out of hospital services. We have worked

closely with our local provider to agree the level of reduced emergency admission activity and to develop plans to further strengthen community working, investing further funding into the community contract this year.

- In line with the underlying principles of the BCF Programme the local area is committed to funding out of hospital commissioned services. This is demonstrated in the planning return expenditure plan. More detailed examples of these services are:-
- The CCG has negotiated with Providers a shift in funding streams from the funding of emergency admissions to the increased funding in community services. This has been possible as the demonstration of the impact of the schemes during 2016/17 has again instilled confidence in the future delivery of impact going forward. **There has been an overall reduction in emergency admissions in Wolverhampton of 1,655 when compared to the previous year of which 35% at least can be directly attributable to the BCF Programme schemes.** As a result of this we have agreed a BCF targets for 2017-18 of reduction in admissions of 1,677. Emergency admission performance data for 2016-17 is shown in the BCF dashboard extract (*Figure 18*).

*Figure 18 – Current Performance – Emergency Admissions*

BCF Monitoring	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Full year
Baseline (15/16 Activity)	1990	1960	1966	1992	1833	2100	2326	2228	2161	2187	2054	2035	24842
16/17 Actual Activity - Total Emergencies	1968	1954	1964	1953	1752	1855	1946	1996	1980	2072	1793	1954	23187
Variance	-22	-6	-2	-39	-81	-245	-380	-232	-181	-115	-271	-81	-1655
Variance (baseline v 16/17)	-1%	0%	0%	-2%	-4%	-12%	-16%	-10%	-8%	-5%	-13%	-4%	-7%
16/17 Actual Activity - All Providers Total EM	2124	2139	2133	2163	1919	2035	2118	2160	2151	2243	1929	2102	

- The Programme is enhancing relationships with voluntary sector providers to support out of hospital services. Through a Grant Policy Framework a number of contracts have been awarded to voluntary sector organisations to support the teams in their delivery of support to the people of Wolverhampton. These schemes include a telephone befriending service with the aim of reducing social isolation, an advice and education Programme for persons with long term conditions, a support network for those at end of life and tailor made packages of support for targeted groups with aim of reducing subsequent need and dependency on NHS services and promote social inclusion.
- Two step up beds have been commissioned and are ring fenced for use by the Rapid Intervention teams for up to 7 days. These beds will increase the opportunity for avoiding emergency admission and retaining people in the community in a safe environment.
- The Street Triage/Mental Health crisis car is an example of collaborative working between organisations to provide care out of hospital.
- The Programme also commissions P3 a voluntary sector organisation that supports persons with mental health issues that are homeless so that when they hit emergency services help is given to identify suitable accommodation for the individual not in a hospital setting.
- Preventative mental health services – the council commissions Starfish to provide support to community groups outreach and one-one support for people with low level mental health provisions.
- For Social Prescribing, Wolverhampton CCG in partnership with Wolverhampton Voluntary Sector Council, have launched a twelve month Social Prescribing Pilot to provide an alternative to and compliment Primary Care (see [Delivery Model - Section 5, p24](#) for further detail).
- WCCG is working with colleagues in RWT and colleagues in Staffordshire in the delivery of a Research project around Health Coaching. Working with Health Navigator we are undertaking a project which sees persons with high Outpatient attendances, A&E attendances and emergency admissions being supported by Health Coached. These health coaches meet with



the person and set up an individualised care management plan looking at their holistic health and care needs. The project will run for two years.

- Work is progressing with housing colleagues across sectors to shape and co-design the integrated process to access DFGs and other housing support and adaptations, enabling people to be as independent as possible and remain out of hospital wherever appropriate.
- **No additional target has been set for Non Elective Admissions** and therefore no contingency funds have been necessary to establish.

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#### 10.4 National Condition 4 - Implementation of the High Impact Model for Managing Transfers of Care

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- **Wolverhampton is in the process of a robust self-evaluation against the High Impact model with** the objective of ensuring that any gaps are identified and action plans are being developed to address. The self-evaluation is being jointly undertaken to ensure a Wolverhampton perspective and will be presented to both BCF Programme Board and A&E Delivery Board for assurance and approval of action plans.
- **There is a D2A programme that is working to develop and implement a Discharge to Assess model in Wolverhampton.** This is led by the Service Director for Adults at CWC with all key stakeholders being involved in the design and implementation. The focus of this work is to get people home from hospital as soon as it is clinically appropriate to do so. Where a person no longer needs acute care but does needs further assessment, rehabilitation and reablement this will happen in a community setting. Objectives are to:-
  - support admission avoidance where appropriate
  - support timely discharge from hospital
  - maintain independence wherever possible
  - reduce the level of long term packages of care
  - have a net neutral impact on the health and social care economy
  - provide a 7 day service
- **The D2A project will be achieved by two projects running concurrently to deliver the objectives. Project 1: Moving people out of acute care into a community health or social care setting.** Deliverables will include:
  - A Wolverhampton integrated discharge to assess offer
  - A trusted assessment screening tool for identifying on-going health and social care issues that will be assessed further in a community setting.
  - Simplified clear criteria for access to Pathway 1, 2 and 3 services
  - A single referral hub for all discharge to assess community health and social care services – this will involve a re-design of current services
  - Agreement and sign up from neighbouring authorities with regard to the implementation of the D2A pathways that all persons at RWT will follow
  - Clear pathways from ED into D2A services
  - New referral processes where necessary
  - Information for staff and persons about pathways and referral criteria
  - Engagement with mental health services to understand existing pathways into mental health and to identify gaps in provision
  - A reduction in delayed transfers due to medication or equipment not being available promptly.
  - Improved communication and information flows from acute care into community settings
  - An evaluation framework for the D2A programme
- **The Rationale for project 1 is-**

- At present numerous professionals may be asked to assess a person before he or she is deemed ready to move. This can cause delay. This project will develop a single trusted assessment to identify issues to be resolved once the acute episode is finished.
- Referrals for community services are made in a number of ways – through WUCTAS, through a social care referral point and between health and social care professionals. Ensuring the correct referral route to the most appropriate service relies on the individual knowledge of a range of services and professionals. This can slow down the process. The project will produce a business case for a single referral hub for D2A services which will describe the operating model. The project will also be responsible for the development and implementation of the hub.
- Many persons attend ED and then have their hospital admission diverted. Some will need on-going assessment and reablement in the community and should have access to D2A services. This project will develop the pathways from ED into these.
- The group is tasked with ensuring that persons receive the appropriate medication on discharge from hospital and that the provision of TTOs does not delay transfer and that the appropriate equipment and adaptations are available to persons in a timely manner on Pathway 1.
- This project will also be responsible for ensuring smooth information flows from hospital to the referral hub and out into community services. Wherever possible information should be collected once and shared with all relevant parties.
- It will be vital to demonstrate that the new D2A pathways are being used for the appropriate persons and that they are having a positive impact on outcomes and quality of life. This project will agree evaluation metrics, ensure that baseline information is available and that systems are in place for capturing data to support evaluation.
- **Project 2: Developing appropriate Discharge to Assess services utilising the pooled budget as per the section 75 agreement for the Better Care Fund. Deliverables will include:**
  - The development of jointly funded services in the community that facilitate the individual to return to his/her usual place of residence, as soon as possible, for people who do not require admission for acute care or have completed an acute episode.
  - Assessment(s) currently undertaken in an acute setting will now happen in the community.
  - All persons on the pathway receive a full assessment on arrival at the D2A service, have a care plan that identifies their rehabilitation and reablement potential with goals to achieve this and regular review
  - A reduction in the length of stay for persons across all D2A pathways
  - Services commissioned for each pathway with standard referral criteria and the same standard level of wrap around care.
  - Care homes commissioned that can demonstrate commitment to a cultural change to reablement and rehabilitation
  - All affected staff groups training needs identified and an on-going programme of workforce development is agreed and implemented.
  - A clear, co-produced communications plan to all stakeholders including a comprehensive information campaign to health and social care staff about the new pathways and how persons' are informed of and access them
- **The rationale for project 2 is:-**

- One of the reasons persons are admitted/ delayed in New Cross is because of the range of services available and a lack of understanding about which is the most appropriate. There are 3 levels of care for persons on the discharge to assess pathways and the services that support them should have clear referral criteria consistent with the pathway and assessed needs of persons and be grouped in fewer places offering an equitable geographic spread. The purpose of this project is to ensure future provision reflects this. It will involve reviewing capacity to ensure the service can meet demand, refining the referral criteria and reviewing provision in residential and nursing homes for pathway 2 and 3. This may result in a change of service provision.
- Persons on the D2A pathways will have a multi-disciplinary assessment of their needs undertaken in the community setting, an agreed care plan that identifies milestones and goals and a discharge date. There will be regular planned multi-disciplinary assessment of progress against these goals. The purpose of this project is to ensure that these principles and culture are adopted in all services on the pathway and that staff receive the training needed to achieve this. The project will also look at whether there are any additional clinical skills needed to manage persons (often with increased complexity) in the community and identify training needs. This work will also focus on developing clear messages, in the most appropriate form, to persons and staff about the D2A referral pathways and criteria. Clear agreed messages to persons will explain the purpose of D2A i.e. of further assessment and rehabilitation in the community and will ensure all staff involved in the delivery of care to the persons place emphasis on its' short term nature.
- A significant proportion of the people who are delayed in hospital do not live in Wolverhampton. A medium term aspiration is to get agreement that these people are moved into their local area for assessment by the relevant authority. Alternatively there would need to be agreed agreement that out of area persons are transferred into a Wolverhampton D2A service as soon as they have become medically ready and assessed promptly by staff from the local authority covering the area where they live. This would involve charging the authority concerned.

## 10.5 Maintaining Progress on the 2016-17 National Conditions

### 10.5.1 Seven day services

- The Programme already has a number of services that support service delivery on a 7 day basis. The Community Intermediate Care Team (CICT), Home Access Reablement Programme (HARP), Bradley Reablement Service and Therapy Access Team services are available 7 days a week from 8.00am until 8.00pm. The Council's therapy led resource beds in the community and the nurse led rapid intervention beds at West Park Hospital can be accessed 7 days a week. These services all support the existing acute and emergency services and the developing community teams. We have commissioned 2 step-up beds that are accessible 7 days per week to support the admission avoidance agenda.
- Our Rapid Response pilot has now moved into an embedded 7 day admission avoidance service and is currently undergoing evaluation. The co-location of social care AMHPS in the Urgent Care Centre across weekends and bank holiday periods is now complete.
- As development of the programme progresses and in conjunction with provider colleagues, all new integrated services will have a phased approach to 7 day service delivery where appropriate in order to prevent avoidable admissions and support timely discharge.
- Wolverhampton is working with NHS England to be an early adopter of 7 day services and the BCF partners are working collaboratively to develop an implementation plan for delivery. A project group has been set up by RWT, which includes representation from: Wolverhampton

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CCG, CWC and BCPFT to collaboratively implement the plan.

- The programme will also explore how 7 day services can be supported by other organisations such as Primary Care and Voluntary Sector.
- There are now step up and step down beds being piloted with both offering a 7 day service

### 10.5.2 Data Sharing

- We now have a signed DSA to cover BCF in Wolverhampton, which has been developed and approved by CCG, LA, RWT and BCPFT. This enables front line staff to deliver more effective care to the population of Wolverhampton.
- The progress on data sharing has underpinned and enabled the successful implementation of the “Fibonacci” IT system that pulls health and social care data into one view for members of the Community multi-disciplinary team. This enables front line staff to manage persons more effectively understanding all of the contacts and interventions that the person has undergone, relevant to their care management. The system is co-commissioned by CCG/LA/RWT/BCPFT. We continue, through the Local Digital Roadmap Group to explore options for an Integrated H&SC record and for systems to provide H&S care data to holistically inform our commissioning decisions.
- Progress is also being made around enabling the use of the NHS number as the key data field. Social Care systems currently reporting a figure of 85% and plans in place to identify and resolve the issues connected to the unmatched 15%.

### 10.5.3 Joint Planning and Assessment

- Work is being undertaken by the emerging CNT’s to identify a caseload for proactive case management. The proportion of the local population who receive case management and a named care coordinator will be the most vulnerable and this group will be identified via a risk stratification tool. This is being done by two methods:-
- A consolidated view of current health and social care caseload within each of the 3 localities to identify a cohort of persons that would benefit from a joint approach of care planning. This is undertaken during regular MDT meetings where health professionals and social care staff meet to agree a joint approach to assessments and care planning.
- Community matrons working with individual GP practices to identify a cohort of persons, based on risk stratification that would also benefit from a joint care planning approach from the integrated health and social care teams. People identified are either managed directly by the team of community matrons or referred into the MDT for a collaborative management plan to be developed.
- As we move forward we will be developing a more Primary Care MDT focus
- As the CNT’s develop further and become more mature this approach will be embedded in their ways of working. This will be further enhanced when the teams become co-located. Work is underway with estates colleagues to identify available and suitable premises in each of the 3 localities and also to identify capital funding to enable this to happen. The opportunity to align to existing bids for new build premises within Primary Care is being explored as part of the longer term estate planning solution.
- The teams will develop an approach whereby each person is allocated a named accountable professional dependent upon their primary need.
- The CNT’s are currently meeting on a monthly basis to discuss their caseload and a joint approach to care planning. The outcome of these meetings are recorded and updated accordingly into a care management plan. The next phase to have these available in a single

person record. This is the first phase of development and our plans describe how these teams will be enhanced in the future.

## 11. National Metrics

### 11.1 Non-Elective Admissions

- **The non-elective admissions (NEL) target reduction for 2017/18 has been set at 1,677.** This figure has been reached through discussion with RWT community teams, contracts and clinicians (both primary and secondary care) who have reviewed the conditions that people are admitted with against the schemes that are in place through BCF and as an outcome have agreed on the potential impact (*see Figure 19 below*).

Figure 19 – Non Elective Admissions Plan 2017-18

BCF Monitoring - 2017-18 Plans	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Full Year
Total NEL - BCF Related Plan	914	943	927	955	888	898	933	958	973	954	916	967	11,226
BCF Planned Reductions	-140	-140	-140	-140	-140	-140	-140	-140	-140	-139	-139	-139	-1,677
Total NEL - Non BCF Related Planned	984	1,022	1,006	1,043	935	959	1,005	1,057	1,071	1,044	1,010	1,064	12,200
<b>Total NEL</b>	<b>1,758</b>	<b>1,825</b>	<b>1,793</b>	<b>1,858</b>	<b>1,683</b>	<b>1,717</b>	<b>1,798</b>	<b>1,875</b>	<b>1,904</b>	<b>1,859</b>	<b>1,787</b>	<b>1,892</b>	<b>21,749</b>

- **This will be a challenge**, and to contextualise in 2016/17 Wolverhampton achieved an overall reduction in NEL of 1,655, with 575 of the typically most complex cases directly attributable to the BCF Programme.
- The target for 2017/18 was set based firstly on evidence of deliverability of last year and whilst the target was not achieved last year a number of reasons are known for this (staff recruitment, influx of pneumonia in the winter months). **By continuing to work with our provider partners and with continued investment into community services we are confident that the set target, whilst challenging, is achievable if all plans are delivered.**
- **Secondly, the determination of the target has been very much clinically led.** Our community nursing teams, GPs and Consultant geriatrician have reviewed the conditions that people are being admitted for, alongside the interventions that we have and are planning to put in place, and have estimated the impact that the programme can, in theory, make on reducing emergency admissions.
- **No other reductions have been set for NEL admissions** in the CCG Operating Plan.

### 11.2 Admissions to Residential Care

- **The 'Long-term support needs of older people (aged 65 and over) met by admission to**

**residential and nursing care homes, per 100,000 population’ target has been set at 260 admissions** (an average of between 21 and 22 per month). The total number of admissions in 2016/17 was 385 – an average of 32 a month.

- In 2015/16, Wolverhampton was in the top quartile among comparators with admissions of 299 – an average of 25 a month, but was in the lower-mid quartile regionally and nationally. Based on 2015/16 data, to be in the top quartile regionally there would need to be fewer than 234 admissions (an average of 19-20 a month) and to be in the top quartile nationally there would need to be fewer than 219 admissions (an average of 18 a month).

**Graph to go here with new targets**

		Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	644.8	638.0	698.8	581.9
	Numerator	273	273	299	252
	Denominator	42,338	42,787	42,787	43,307

- Service redesign to promote independence and strengthen access to treatment and support in the community is well underway, as is work to support the development of mechanisms to track it.
- The CWC is in the process of procuring the Care and Health Track system and is currently working to agree the content and delivery timescales. This will provide access to much more detailed information about health and social care needs across the City.

**11.3 Effectiveness of Reablement**

- **The proposed target for the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services is 80.3% - the same as 2016/17.** Although the target was not achieved, there will be additional reablement capacity with the introduction of the externalised service which it is proposed will be twin tracked with the internal HARP services as part of the IBCF monies. Further work will be done to understand the reasons why people do not remain at home following reablement to understand what else can be done to further maximise its effectiveness.
- The plans set out within this BCF submission to further increase the reablement offer to the citizens of Wolverhampton both within the community and on discharge from hospital further. Increasing the offer of reablement through a more widely encompassing selection and identification criteria for people who would benefit from the offer, often leads to a decline in overall reported effectiveness due a lessening of the ‘cherry picking’ effect that more stringent selection criteria can produce. It is therefore believed that maintenance of current performance against an increased reablement offer is realistic while providing a degree of ambition.
- The following metric has been selected:-

‘Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services’

**Need to update graph for targets**

Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17
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Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	80.5%	94.3%	75.6%	80.3%
	Numerator	330	330	195	490
	Denominator	410	350	258	610

#### 11.4 Delayed Transfers of Care

- The requirement for measuring delayed transfers of care has changed for 2017-19. There is a national target that has been set that by September, the number of delayed transfers of care should be no more than 3.5% of occupied bed nights. Although the detailed methodology has not been released for this, it is understood that the measure most likely uses the snapshot DTOC figure (number of people who are delayed at midnight on the last Thursday of the month) and the average daily occupied consultant led bed nights as published in the quarterly reports. Occupied bed nights are only available by Trust. Using data for the Royal Wolverhampton Trust, the figures for 2016/17 are as follows:

**Need DTOC graphs – then some narrative (none to bring over from last submission)**

#### 12. Budgets

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**WOLVERHAMPTON CCG**
**Governing Body**
**11<sup>th</sup> July 2017**
**Agenda item 11**

<b>TITLE OF REPORT:</b>	<b>Commissioning Committee – Reporting Period May 2017</b>
<b>AUTHOR(s) OF REPORT:</b>	Mr Steven Marshall
<b>MANAGEMENT LEAD:</b>	Mr Steven Marshall
<b>PURPOSE OF REPORT:</b>	To provide the Governing Body of Wolverhampton Clinical Commissioning Group (CCG) with an update from the Commissioning Committee in May 2017.
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This Report is intended for the public domain.
<b>KEY POINTS:</b>	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.
<b>RECOMMENDATION:</b>	That the report is noted.
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	[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 May 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 12 (March 2017) for activity and finance.

#### ***Royal Wolverhampton NHS Trust***

Sustainability and Transformation Fund (STF) indicators – The Trust has agreed trajectories for 2017/18 with NHS Improvement (NHSI) for A&E and RTT. Agreement is awaited on the Cancer 62 day target.

MRI/CT and Plain film X Rays – A concern has been raised with the Trust with regards to the backlog of unreported scans. The provider has assured the CCG that there are no concerns as a result of these delays. The Trust report that the backlog is on track to be cleared by July 2017. This remains on the agenda of the Clinical Quality Review and Contract Review meetings.

Exception Reporting Proposal – The provider has confirmed that they will start populating exception reports in Month 1 (June 17). The final details are yet to be finalised and the agreed revision varied into the contract. This will increase the assurance for the CCG of the level of performance.

Performance Sanctions – Total fines for Month 12 - £55,450.

Business Cases for fines/MRET/readmissions – A revised submission has been accepted by the CCG and a letter is to be sent to the Trust confirming this. The letter will also outline a more proactive process for 2017/18 which will encourage the Trust to submit business cases throughout the year. Clarification will also be given to what is the responsibility of the A&E Delivery Board versus what will be directed through the normal contracting route.

### ***Black Country Partnership Foundation Trust***

Fines / Sanctions – Sanctions applied, year to date, remain at £5,000. This relates to a safeguarding breach in Month 10. There were no further sanctions in Month 12.

Quality – A response has been received from the Trust in respect of the letter sent by the CCG raising concerns about the Trusts application of the Care Programme Approach for all patients following two patient deaths. Internal CCG feedback is awaited regarding the assurance taken from this response.

### ***Other contracts***

#### ***Urgent Care Centre***

A time limited Improvement Board has been established. The Board will be chaired by the Executive Nurse of Quality and Risk. An extensive action plan has been developed and incorporates issues raised by the CCG and CQC. It was noted that the Quality and Safety Committee will have an overview of the quality issues and more details discussions will be held there.

#### ***WMAS- Non-Emergency Patient Transport (NEPT)***

Concerns have been raised with the provider relating to performance and the CCG has advised WMAS that the receipt of Quarter 1 data (April to June 17) is awaited before a decision is made on raising a Contract Performance Notice.

### ***Procurement Update***

Mr Middlemiss highlighted that the schedule has been updated and the procurement completed last year removed. The schedule shows procurements underway and those due to commence. This will continue to be updated.

Procurement Policy Proposal 2017/18 – The Committee reviewed an updated proposal which included information pertaining to the new procurement regulations.

The proposal could not be signed off as the meeting was not quorate and will be brought back to the next meeting.

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

### **3. RECOMMENDATIONS**

- Receive and discuss the report.
- Note the action being taken.

**Name:** Steven Marshall  
**Job Title:** Director of Strategy and Transformation  
**Date:** 31<sup>st</sup> May 2017

**WOLVERHAMPTON CCG**

**Governing Body**  
**11 July 2017**

**Agenda item 11**

<b>TITLE OF REPORT:</b>	<b>Commissioning Committee – Reporting Period June 2017</b>
<b>AUTHOR(s) OF REPORT:</b>	Mr Steven Marshall
<b>MANAGEMENT LEAD:</b>	Mr Steven Marshall
<b>PURPOSE OF REPORT:</b>	To provide the Governing Body of Wolverhampton Clinical Commissioning Group (CCG) with an update from the Commissioning Committee in June 2017.
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This Report is intended for the public domain.
<b>KEY POINTS:</b>	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.
<b>RECOMMENDATION:</b>	That the report is noted.
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	[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 June 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 1 (June 2017) for activity and finance.

#### ***Royal Wolverhampton NHS Trust***

Sustainability and Transformation Fund (STF) indicators – The Trust has agreed trajectories for 2017/18 with NHS Improvement (NHSI) for A&E and RTT targets and the Cancer 62 day target.

Exception Reporting Proposal – The provider has confirmed that they will start populating exception reports in Month 1 (June 17) for National Indicators and Month 2 for Local Indicators.

Performance Sanctions – Total fines over 12 month period - £501,750.00.

Business Cases for fines/MRET/readmissions – New processes have been proposed with the Trust being asked to submit business cases for fines monies to be submitted throughout the year rather than at the end of the year. It was also proposed that reinvested sanctions money would also be available to be bid for across the Black Country and not just by the Trust. To date no feedback had yet been received by the CCG from the Trust.

Dermatology – Consultant vacancies in the dermatology department continued to be of concern. This could potentially impact on the department at Cannock Hospital. Mr Reynolds asked if the GPs in the Community Dermatology Services could help to alleviate the pressures on the hospital.

A GP perspective felt that Hospital Dermatology was working better than Community Dermatology at the moment. The Chair asked if this had been feedback as it seemed that this was something that needed to be looked at. It



was agreed that it would be beneficial to carry out an audit of the uptake of Community Dermatology.

### ***Black Country Partnership Foundation Trust***

Fines / Sanctions – Sanctions applied, year to date, remain at £5,000. This relates to a safeguarding breach in Month 10. There were no further sanctions in Month 12.

### ***Other contracts***

#### ***Urgent Care Centre***

There had been a year end underperformance by Vocare for 16/17 for which a cost had been agreed and paid for by Vocare. Following receipt of a Business case, it was agreed that the CCG would give back to Vocare some of the sanctioned monies for their out of hours triage. 50% of the money would be given at the start and the remainder would be allocated following improvement in the 6 identified performance indicators.

#### ***WMAS- Non-Emergency Patient Transport (NEPT)***

A further letter was in the process of being sent and notice was being raised. An action plan had been put in place.

### ***Primary Medical Services Contracts***

Ettingshall Medical Centre – Mutual agreement had been reached with the current providers to end the contract and mobilisation was under way.

Prestbury Medical Centre – It had been agreed at the Primary Care Commissioning Committee that the Dunkley Street branch would be closed. Patients would be absorbed by the main surgery and patients would also be able to join other practices in the area if they wished to.

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

- 2.2 A 12 week pilot ran with the Rapid Response Team managing two commissioned beds (with 2 further beds utilised when needed) for Step Up patients to use which would help with avoiding admissions to hospital. The CSU had conducted a limited evaluation at the end of the pilot. The

evaluation concluded that it was a good admissions service, the GP covering the home praised the service and it was favourable by patients and carers. An audit conducted by a geriatric consultant showed that 86% of patients were in the right place and 56% were discharged home. The evaluation recommend that the service continued. There would be no extra costings as this would be covered under the block booking of the beds.

The Executive Lead for Quality and Risk advised that Probert Court where the Step Up beds were based was currently suspended to accept Step Down patients. The Step Up patients would continue to use the beds as they were managed by the Rapid Response Team. The Committee discussed this and the recommendation to continue the Step Up Bed Service however due to current situation regarding the Step Down beds, this would need to be monitored in case of any impact on the patients.

### 3. RECOMMENDATIONS

- Receive and discuss the report.
- Note the action being taken.

**Name:** Steven Marshall  
**Job Title:** Director of Strategy and Transformation  
**Date:** 30 June 2017



**WOLVERHAMPTON CCG**  
**Governing Body**  
**11<sup>th</sup> July 2017**

**Agenda item 12**

<b>Title of Report:</b>	<b>Executive Summary from the Quality and Safety Committee</b>
<b>Report of:</b>	Manjeet Garcha Director of Nursing and Quality
<b>Contact:</b>	Manjeet.garcha@nhs.net
<b>Governing Body Action Required:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>Purpose of Report:</b>	Provides assurance on quality and safety of care, and any exception reports that the Governing Body should be sighted on.
<b>Public or Private:</b>	This report is intended for the Public Governing Body
<b>Relevance to Board Assurance Framework/Strategic Objectives:</b>	<ol style="list-style-type: none"> <li>1. Improving the quality and safety of the services we commission</li> <li>2. Reducing health inequalities in Wolverhampton</li> <li>3. System effectiveness delivered within our financial envelope</li> </ol>

Key areas of concern are highlighted for the Governing Body below:

	<b>Level 2 RAPS breached escalation to executives and/or contracting/Risk Summit/NHSE escalation</b>
	<b>Level 2 RAPS in place</b>
	<b>Level 1 close monitoring</b>
	<b>Level 1 business as usual</b>

Key Issue	Comments	RAG	Page in report
Mortality	Raised SHMI/HSMR. Action plan in place, Trust has commissioned independent coding, diagnostic, palliative and case note reviews. Internal practices strengthened.		9
Urgent Care Provider	Improvement Board convened, action plan in place. 6 weekly meetings. Immediate improvements for PREVENT training, paediatric training and patient flow monitored.		11
Maternity Performance Issues	No specific quality issues identified however, key performance indicators on maternity dashboard a concern which could impact on quality and safety. NHSE escalated at QSG		10
Step Down care home provider	Quality and health and safety concerns. Escalation meeting convened. Step down currently suspended		12
Increased number of NEs 16/17	Trust had 5 NEs last year. This is being closely monitored this year to ensure that the significant learning from those events is being embedded and having impact. National scrutiny of some London Trusts with 5 or more NEs in last year.		8
RWT safeguarding level 3 training	Both adults and children training remain under the required levels.		15
Safety, experience and effectiveness	Continuous scrutiny on PIs, SIs, Falls, FFTs, Surveys, NICE, IPC etc.		3-7

## **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 held on the 13<sup>th</sup> June 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 were shared with the Governing Body at the development session on June 27<sup>th</sup> as there was no Governing Body meeting held in June.

## **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 in the last 4 weeks

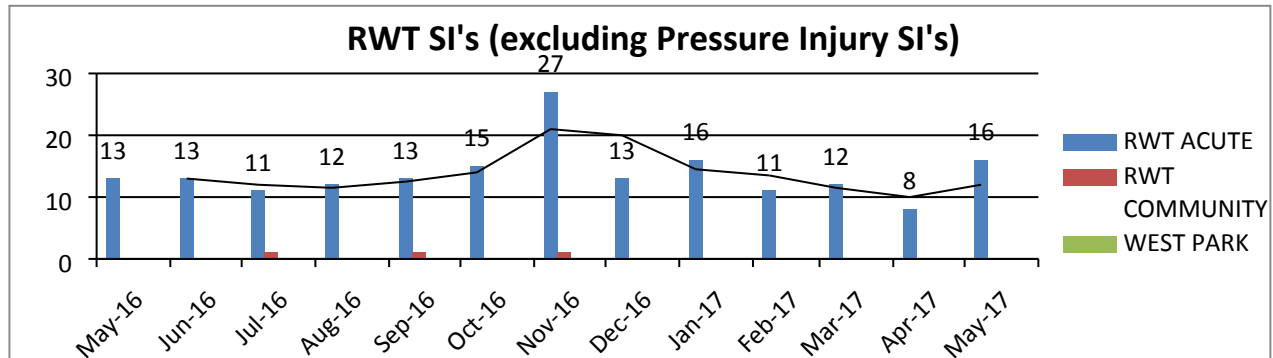
- 1) Step Down activity at a care home provider has been suspended following a poor quality visit. CQC have been notified, a full recovery improvement plan is in place and a directors meeting convened for June 20<sup>th</sup>.
- 2) Improvement Board has been convened following poor quality and performance outcomes with urgent care provider. The March 2017 CQC inspection report is imminent and the organisation is being fully supported by the CCG Quality Team to monitor progress with the improvement plan.
- 3) Concerns have been raised at RWT re quality of maternity services. Whilst no specific quality patient safety issues have been reported, the maternity dashboard is alerting in several areas to give adequate concerns for escalation. This is in progress.
- 4) The above three issues have been escalated to NHSE at the Quality Surveillance Group Meeting in June. NHSE are included in the membership TOR for the Improvement Board and further detailed reports have been requested at the July QSG meeting
- 5) Oxley Lodge Care Home has voluntarily closed in June. All residents have been placed in other settings, this has been managed by LA and CCG Quality Nurse Advisors have been engaged in the whole process. There has been some social media adverse publicity on this issue.
- 6) Three diagnostic delays SIs were reported by RWT. All are currently being investigated. These were discussed in more detail at the QSC to give assurance of the process and a full discussion was held re the action outcomes required from the Trust.
- 7) Three incidents related to deaths post operatively were reported as 'unexpected deaths'. Whilst they meet the reporting criteria and are being fully investigated, they are not deemed to be related to the surgery itself at this stage.

## **4.0 ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST**

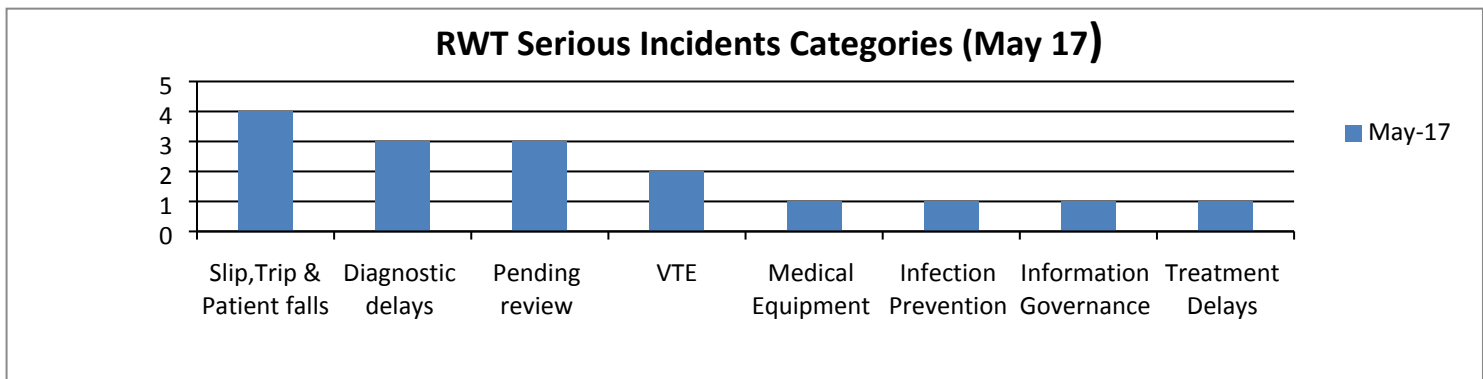
The Governing Body is asked to note the following:

- a) **Serious Incidents** (these are the number of SIs reported by RWT and do not include the PIs).
- b) We observed a drop in reported incidents in April which was not in line with usual reporting trends. There is no key factor with this, however, it was noted that it was Easter vacation and the reports may have been delayed. May showed a slightly higher number which may balance the under reporting in April.

**Fig. 1**



**Fig. 2**



**Fig 2** above shows the 8 most common categories reported by RWT. Sixteen serious incidents were reported by RWT in this reporting period. The most common is slips trips and falls. Please refer to section 6.0 for more detailed report on falls.

#### 4.1 INFECTION PREVENTION

##### 4.1.1 MRSA Bacteraemia

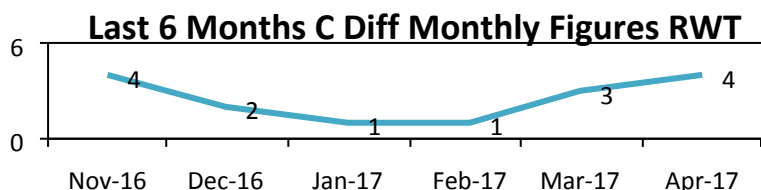
RWT have reported zero MRSA Bacteraemia incidents in 16/17 and ytd in 17/18. This is a fantastic sustained improvement due to the forensic and tight screening regimes in place in all admissions portals at the hospital. The audits for these are monitored at the IP meetings and have continued to be at 100% in all elements of the screening protocol.

##### 4.1.2 Cdiff

The 17/18 trajectory for the RWT is nationally set at 35. The Trust has sustained improvements in Cdiff cases

since December last year. Whilst the Trust breached its annual target for 16/17, improvements were seen in Q3 and Q4. Since then the monthly trajectory of 3 or less has been achieved almost consecutively till the end of March. April 2017 has seen a slight increase to 4 and the Trust is reviewing this to identify any breaches in their standards. The CDiff action plan has been completed and the changes are now embedded in antibiotic stewardship, change to disposable mop heads and other multimodal strategies. Audits continue monthly.

**Fig 3 Cdiff prevalence in the last 6 months.**



**Fig 4 below shows the annual target and monthly trajectory for CDiff positive.**

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	TARGET	Variance
3.00 4	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	2.00	4	35	1

As demonstrated in Fig 4, the Trust is in breach of its April trajectory by 1 case. This will be discussed at the next Trust IPC meeting on 23<sup>rd</sup> June 2017. Sustainability actions continue and key changes are antibiotic changes and the scrutiny re compliance in prescribing.

**4.1.3 CPE**

Four new cases were reported in May. All four were picked up from screen samples from patients who have had recent travel to high incidence or admissions to other hospitals. The Trust continues to progress its plan to develop the business case for the laboratory to cope with the increased demand for sampling.

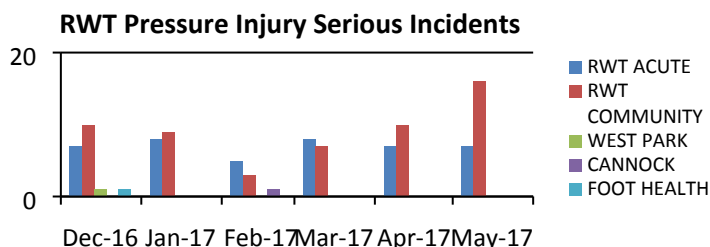
The growing incidence of CPE is one of national concern, there is some collaborative work with intra hospital transfers as this is recognised as a high risk. RWT have shared their data for CPE since 2012/13:

Breakdown of CPE	Total
2012/2013	2
2013/2014	8
2014/2015	8
2015/2016	12
2016/2017	18
2017/2018 to Date (May)	7

## 5.0 Pressure Injury (stage 3)

**Fig 5 Pressure Injury (stage 3)**

Pressure Injuries - RWT Last 6 Months



**Fig. 6 Pressure Injury Outcomes**

Pressure Injury Numbers													
	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Avoidable	16	11	19	10	15	15	19	12	12	11	17	10	7
	30.8%	26.8%	35.2%	28.6%	38.5%	32.6%	43.2%	34.3%	25.0%	26.8%	29.8%	26.3%	16.3%
Unavoidable	36	30	35	25	24	31	25	23	36	30	40	28	36
	69.2%	73.2%	64.8%	71.4%	61.5%	67.4%	56.8%	65.7%	75.0%	73.2%	70.2%	73.7%	83.7%

There was a total of 23 stage 3 pressure injury incidents reported for May 2017 compared to 17 in April. A significant reduction in avoidable pressure injuries has been observed since May 2016 as per Fig 6, however, we continue to monitor and scrutinise all pressure injury incidents especially those classed as 'avoidable'. The CCG attends a weekly pressure injury scrutiny meeting chaired by the Chief Nurse at RWT.

In 2015, 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. Over the last two years, this has now evolved into a wider participation group and preventative actions have been developed.

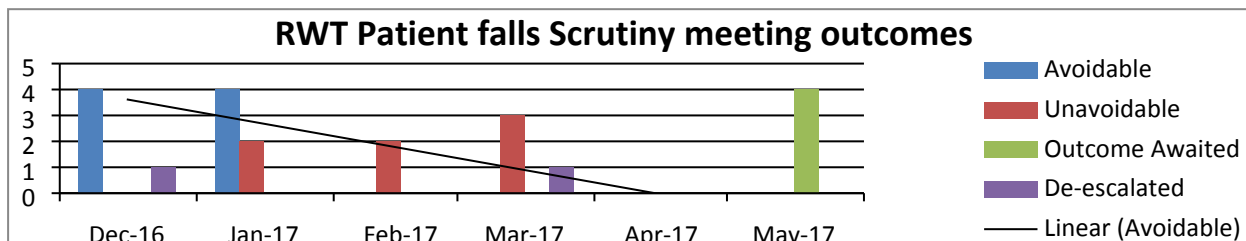
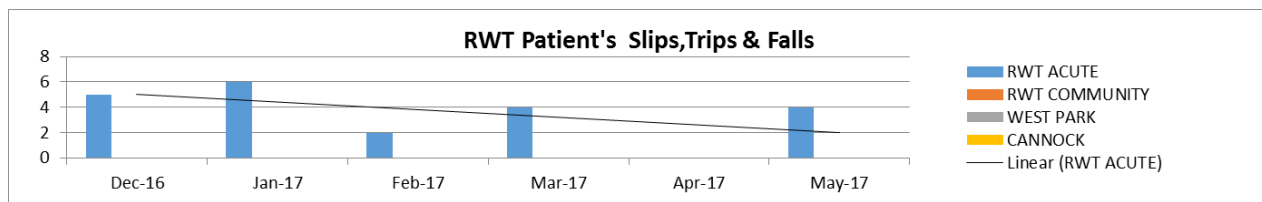
### RWT pressure injury preventative actions:

- 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.
- Evaluating a new mattress with improved heel offloading technology in the North East Locality - evaluations in progress
- Table top exercise to compare heel offloading devices planned for June.
- To analyse slide sheet orders and compare incidents to agree a standard slide sheet for moving and handling to prevent shear and friction.
- The Tissue Viability Team has completed a table top exercise to agree the skin protectant for the Formulary. Two products were a challenge to choose between due to very similar cost savings as

well as patient benefits. Therefore a continence exercise was completed by the Lead Nurse. This process confirmed Med honey 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 was sent out in April. There was 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.

## 6.0 Patient Slip/Trip/Falls RWT Dec 16 to May 17



Zero falls reported in April, followed by 4 in May; all at RWT. No falls have been reported at WPH, Community or Cannock Hospital in the last 6 months. Outcomes are awaited for the May reports; however, no avoidable falls have occurred since January 2017.

Themes emerging from Patient Falls RCA's:

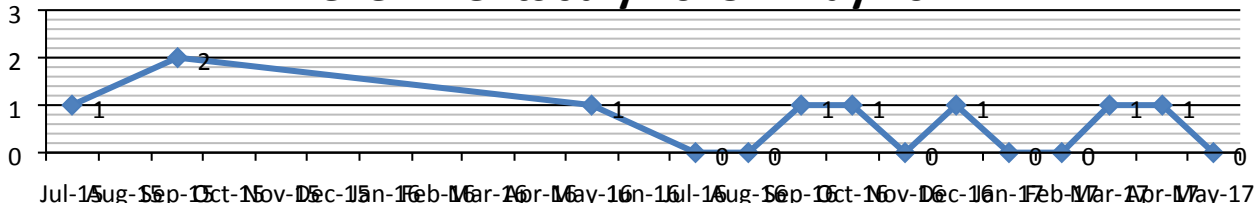
- Delays in patient discharge once medically fit for discharge
- Multiple moves/transfers of patients within hospital
- Patient transfers to inappropriate clinical areas
- Lack of supervision for confused and at high risk of falls patients

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

**7.0 Never Events**

**Never Events July 2015 - May 2017**



**Summary of NEs since July 2015 to May 2017**

<b>Jul-15</b>	<b>1</b>	<b>Retained foreign object post-procedure</b>
<b>Sep-15</b>	<b>2</b>	<b>Wrong site surgery x 2</b>
<b>May-16</b>	<b>1</b>	<b>Retained foreign object post-procedure</b>
<b>Sep-16</b>	<b>1</b>	<b>Wrong site surgery</b>
<b>Oct-16</b>	<b>1</b>	<b>Wrong site surgery</b>
<b>Dec-16</b>	<b>1</b>	<b>Retained foreign object post-procedure</b>
<b>Mar-17</b>	<b>1</b>	<b>Wrong implant/prosthesis</b>
<b>Apr-17</b>	<b>1</b>	<b>Retained foreign object post-procedure</b>

In 16/17 the Trust reported 5 NEs (as shaded above) and there has been 1 NE reported ytd in 17/18. Full RCAs have been undertaken and the learning has been shared at a table top review meeting held in January this year. The Trust assured the CCG with the following actions at the meeting and in writing post meeting:

- Human factors training and in addition Professor Matthew Cooke has undertaken an independent review of the ED
- Sign Up To Safety
- National and Local SSIPs are assisting with bringing standardisation practice (across acute and community settings)
- Cardiothoracic surgery management has been moved to within the main theatre management domain
- Implementation of a 'use ultrasound before surgery' policy
- Improved HR processes for human factor issues in NEs
- Consent forms reviewed re removal of patients tooth prior to surgery
- Maternity, swab competency training videos used for training
- Learning strategy to consider if staff affected or involved in NEs will share a 'positive story'
- Single use packs introduced
- Out of date packs reviewed with sterile services/operational staff
- Registrar escalation to consultants strengthened
- NHSI liaising with higher education providers to influence curriculum
- Confirmation bias training for appropriate staff
- Availability of cylinders to be improved in the case of walled oxygen equipment failure



## 8.0 Mortality

RWTs most recent HSMR and SHMI data is indicating deterioration in their position. There has not been a concern regarding quality of care i.e. increase in SIs or unexpected deaths, no outbreaks of Cdiff or other infections which had not been managed according to protocol and the MORAG have been assured on the outcomes of the case note reviews. However, some significant targeted work is being carried in collaboration with the RWT, CCG, NHSi and the CSU. The Trust has commenced the following actions;

- 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.
- 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.
- 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).
- 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.
- 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. An external company has been commissioned.
- The Trust has commissioned CHKS to undertake a coding review.
- A more comprehensive report has been collated by CSU. The findings have been shared with RWT.  
Update from RWT at the May CQRM:  
All external and internal reviews are in progress and once analysis is available this will be shared at the mortality review groups. This item remains on the CQRM agenda as a standing item and the Trust have been requested to present mortality information on the monthly Integrated Performance & Quality Report.

## 9.0 Health and Safety

Q1 Health and Safety Report is being prepared for presentation to SMT and QSC in July. As reported previously the actions identified by the Fire Inspection have now been completed and all documentation has been received by the CCG. The CCG is compliant for Fire Safety and an emergency PEEP (Personal evacuation escape plan) is in place for appropriate staff. As required, Health and Safety Administrator training has been completed by Quality Assurance Officer and the NEBOSH training is on schedule for completion in July by the Head of Quality and Risk.

## 10.0 EDS2 Compliance

The CCG met its statutory obligation to publish its EDS2 on the CCG website. Following this, work has continued to progress from 'developing' to 'achieving' in several areas. An update report is planned for 11<sup>th</sup> July 2017.

## 11.0 Maternity

Since Walsall Hospitals NHS Trust were rated as 'inadequate' by the CQC, there has been an agreement in place that Royal Wolverhampton Hospitals NHS Trust (RWT) will take 500 deliveries from Walsall to ease the pressure and provide a safe service for mums and babies.

Over the last year, this has been monitored closely and some key issues have emerged over a period of time. A brief summary of the key KPIs is demonstrated below:

- a) The number of women booking to give birth at RWT has increased significantly month by month in the last 12 months.
- b) The midwife to birth ratio has deteriorated from 1:29.8 in April 2016 to 1:31 in April 2017
- c) Midwifery sickness rate was 5.3% in April 2016, peaked to a high of 7.3% in March 2017 and the Trust have not provided data for April and May.
- d) Midwifery vacancy rate is 4% which has deteriorated from 2.2% in April 2016. Following an overseas recruitment campaign there were zero vacancies in June and July, however, the overseas midwives have not remained within the Trust and the vacancy rate has continued to decline.
- e) Bookings have increased from surrounding areas as Burton, Dudley, Shropshire including Telford, Walsall (which falls outside of the capped arrangements).
- f) NHSE Quality Surveillance Group has requested a more detailed report in July to review the current escalation rating.

Actions taken by CCG:

- a) Monthly discussion at CQRMs for assurance on actions i.e. recruitment plans, HR activity to address sickness, supervision and support for new staff.
- b) Current escalated Maternity commissioner meetings with RWT.
- c) Escalation to Maternity STP (strategic and operational group meeting on 21<sup>st</sup> June 2017).
- d) Escalation meetings with RWT to discuss options.
- e) RWT and CCG entry on risk register.

## 12.0 Annual Quality Accounts

RWT have shared their Quality Account Report for 16/17. This has been extensively reviewed and the CCG Chief Officer has responded with a written and signed statement.

## 13.0 BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST

### Serious Incidents

There was 1 SI reported by BCPFT for May 2017. This is currently being investigated by the Trust.

On-going **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 reviewed the RCAs (several iterations) and in the absence of demonstrable evidence that the Trust used all their available resource and policy to prevent this incident from happening again, the SI was allocated to the Trust as ‘avoidable’. A lessons learnt meeting is in the diary for July.

### 13.1 CQRM theme Adults Services (2<sup>nd</sup> May 2017)

- It was noted from Quarter 4 reporting that 18 serious incidents had been reported. The highest number of these incidents related to physical and non-physical aggression.
- It was reported that there had been an overall 1.23% increase of sickness absence from February. Themes pertaining to this related to coughs, colds and stress related illnesses. It was noted that the vacancy rate of 12.43% had decreased from 12.73% in the last reporting period.
- It was confirmed that the ageing nursing workforce had been reported as a risk for the organisation and an update on the recruitment retention strategy was requested.
- The organisation recognised a significant theme in complaints regarding staff attitude and were currently looking to roll out communication training for staff.
- As part of the Staff Survey the Trust reported that 49% of staff would recommend the organisation as a place to work. 57% would be happy for a relative to receive care. 82% know who the senior managers are. 92% report violence and aggression. 87% believe equal opportunities for career progression exist.

Recovery Action plans are in place for improving staff sickness, workforce strategy, complaints and staff surveys. This action is escalated at CQRMs.

## 14.0 OTHER PROVIDERS

### 14.1 Out of Hours/Urgent Care

- Following signing of contract, the CCG and Provider held the first CQRM in November 2016. Several issues came to light regarding quality and performance of the provider service provision: i.e. no SI reporting policy or reporting systems in place, poor staff awareness of SI reporting and investigating processes; inadequate safeguarding training for front line staff; poor governance at senior level, poor scrutiny at senior executive level, poor response rates for out of hours patients, poor quality of data submitted to the CCG.
- Actions taken by CCG
- Support for staff to get the right systems into place
- Added to CCG Risk Register
- Expert advice and support from key experts at CCG i.e. safeguarding leads, PS leads, urgent care lead
- January 2017 director to director meeting with Provider Chief Executive, Medical Director, CCG AO, Director of Nursing and Head of Quality and Risk. Actions put into place for immediate address
- Actions monitored from Feb to March with poor improvement
- March CQC Inspection (verbal feedback several immediate recommendations but no improvement notice sanction)
- April Improvement Board instigated with executive membership from CCG, Provider, CQC, NHSE Health Watch have expressed interest to attend and have been accommodated.

- Most recent meeting May 31<sup>st</sup>, extensive action plan in place, CQC report imminent, comms statement in place.
- 6 weekly meetings in diary
- NHSE QSG has requested a more detailed report in July to review the current surveillance rating.

## **14.2 Step Down provider care home**

The CCG currently has a block contract with provider to provide step up and step down beds. Following an early morning quality visit to provider, several concerns were raised re quality of care and health and safety arrangements to safeguard residents at the home. An improvement board is being convened with senior CCG, provider and CQC to address and manage the improvements required. However, on the day of the visit as the concerns were significant, escalated discussions took place at SMT and the service was immediately suspended from admitting any more residents for step down. Following receipt of demonstrable and sustained improvements the suspension will be reconsidered.

## **15.0 Children and Adult Safeguarding**

The Annual Reports for Safeguarding adults and children were presented to and discussed by the QSC in June. Both reports were accepted and both leads congratulated for their continued efforts to ensure that a) the CCG remains competent in its statutory obligations and b) the vulnerable persons of Wolverhampton are safeguarded.

The compliance for mandatory adult safeguarding level 3 was 80% in April and 80% in May. The compliance for mandatory safeguarding children level 3 was 84.3% in April and slight improvement in May at 87.3%.

Both these contractual requirements are monitored via CRM, CQRM and the Trusts Strategic Safeguarding meetings. Training plans are in place and have been shared. Close monitoring continues.

## **15.1 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.

## **15.2 CQC (Safeguarding)**

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 is being monitored by WCCG through a Strategic Group and CQC colleagues in the Central Region. Progress of the action plan is monitored at the Local Children Safeguarding Board; several actions are now complete and all stakeholders held accountable via the Strategic Group.

## **15.3 PREVENT**

NHSEs current assessment of Wolverhampton is ‘not a priority’ therefore providers are not required to report to NHSE. However, PREVENT is now in contract for 17/18 contracts and currently are required to report for contractual and performance monitoring. The current RAG rated concerns are VOCARE (this is part of their improvement plan).

## **15.4 Looked After Children**

The Annual Looked after Children Report was presented to the QSC in June. The Committee noted work activity, statutory obligations and time scales, key challenges and future work plan. The City wide initiative to reduce the number of LAC has been successful but slow. Currently there are 635 children placed in LAC compared to 804 in November 2015. The City wide work continues to attempt to reduce these numbers further. The CCG has robust processes in place to assure the Governing Body that initial and review health assessments are timely, of a good quality and commissioned appropriately.

## **16.0 NHS Funded Health Care Provision**

WCCG continues to meet the requirements of the National Framework. Quarterly reports are presented to the QSC for assurance on patient outcomes and poor care. The team work very closely with the Quality team to share concerns.

### **16.1 Individual Funding Requests**

The annual report for IFR 16/17 was presented to QSC in June. During this time period, a total of 177 applications were received and all are processed as per IFR Policy. No formal appeals were received for WCCG, however, challenges and complaints were received which were handled in line with the commissioning policy and or the CCGs complaints policy. The CSU handled 6 FOI requests pertaining to IFRs during the said reporting period. The report was noted for its assurance and transparency.

## **17.0. Improving Quality in Primary Care**

As of 1<sup>st</sup> April 2017, the CCG has been fully delegated for Primary Care Commissioning. The primary care dashboard is under development and the Improvement Coordinator is managing the transition with particular focus on:

Infection prevention audits: reports will begin to be shared in May.

- Medicines Alerts: health care professionals will be informed about the alerts via the monthly newsletter, in addition by Script Switch messages.
- Friends and Family Tests: more detailed reports are shared at PCCC; however, concerns remain re the 7 practices that continue to not submit. This is being addressed by the new primary care contracts lead.
- Quality Matters: zero new reports in May, however, there are 5 that remain open from March and April. These remain under investigation.
- Formal complaints: zero for the CCG. 10 for NHSE of which the highest number (6) related to clinical treatment.
- CQC new ratings: All Saints and Rose Villas were rated as Good (report published 16<sup>th</sup> May 2017).
- A comprehensive analysis of primary care workforce has been undertaken, the current PC Strategy and Implementation Plan is being reviewed in light of the TOR being reviewed. This is monitored via the PC Strategy Group.

Name: Manjeet Garcha  
 Job Title: Director of Nursing and Quality  
 Date: 16<sup>th</sup> June 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	M Garcha	16 <sup>th</sup> June 17
Public/ Patient View	Commissioning leads	On going
Finance Implications discussed with Finance Team		
Quality Implications discussed with Quality and Risk Team	M Garcha	16 <sup>th</sup> June 17
Medicines Management Implications discussed with Medicines Management team	D Birch	
Equality Implications discussed with CSU Equality and Inclusion Service	J Herbert	1-16 <sup>th</sup> June
Information Governance implications discussed with IG Support Officer	Consideration Applied	On going
Legal/ Policy implications discussed with Corporate Operations Manager	Consideration Applied	On going
Signed off by Report Owner (Must be completed)	M Garcha	20 <sup>th</sup> June 17

**WOLVERHAMPTON CCG**

**GOVERNING BODY**

**11 July 2017**

**Agenda item 13**

<b>Title of Report:</b>	<b>Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 27<sup>th</sup> June 2017</b>
<b>Report of:</b>	Tony Gallagher – Chief Finance Officer
<b>Contact:</b>	Tony Gallagher – Chief Finance Officer
<b>Governing Body Action Required:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>Purpose of Report:</b>	To provide an update of the WCCG Finance and Performance Committee to the Governing Body of the WCCG.
<b>Recommendations:</b>	<ul style="list-style-type: none"><li>• <b>Receive</b> and <b>note</b> the information provided in this report.</li></ul>
<b>Public or Private:</b>	This Report is intended for the public domain.
<b>Relevance to CCG Priority:</b>	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.
<b>Relevance to Board Assurance Framework (BAF):</b>	

<ul style="list-style-type: none"> <li>• <b>Domain 1:</b> A Well Led Organisation</li> </ul>	<p>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.</p>
<ul style="list-style-type: none"> <li>• <b>Domain2:</b> Performance – delivery of commitments and improved outcomes</li> </ul>	<p>The CCG must meet a number of constitutional, national and locally set performance targets.</p>
<ul style="list-style-type: none"> <li>• <b>Domain 3:</b> Financial Management</li> </ul>	<p>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.</p>



## 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
<b>Statutory Duties</b>				
Expenditure not to exceed income	£9.052m surplus	£9.052m surplus	Nil	G
Capital Resource not exceeded	nil	nil	Nil	G
Revenue Resource not exceeded	£401.390m	£401.390m	Nil	G
Revenue Administration Resource not exceeded	£5.535m	£5.535m	Nil	G
<b>Non Statutory Duties</b>				
	<b>YTD Target</b>	<b>YTD Actual</b>	<b>Variance o(u)</b>	<b>RAG</b>
Maximum closing cash balance £'000	338	2,759	2,422	A
Maximum closing cash balance %	1.25%	10.22%	8.97%	A
BPPC NHS by No. Invoices (cum)	95%	99%	-4%	G
BPPC non NHS by No. Invoices (cum)	95%	95%	0%	G
Q PP	£1.77m	£1.77m	£0.01m	A
Programme Cost £'000*	63,919	64,337	419	G
Reserves £'000*	356	0	(356)	G
Running Cost £'000*	922	860	(63)	G
BPPC NHS by Value (cum)	95%	100%	-5%	G
BPPC non NHS by Value (cum)	95%	96%	-1%	G

- The net effect of the three identified lines (\*) is breakeven.
- The Cash balance has exceeded pal due to unanticipated receipt of c £1m from NHSE (see cash section).

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

	Annual Plan £'000	YTD Performance M02			
		Plan £'000	Actual £'000	Variance £'000 o(u)	Var % o(u)
Acute Services	190,491	31,749	31,763	14	0.0%
Mental Health Services	35,366	5,990	6,123	132	2.2%
Community Services	36,947	6,158	6,100	(58)	(0.9%)
Continuing Care/FNC	13,899	2,316	2,431	115	5.0%
Delegated Primary Care	34,477	5,746	5,804	58	1.0%
Prescribing & Quality	51,184	8,531	8,637	107	1.2%
Other Programme	20,572	3,429	3,479	50	1.5%
<b>Total Programme</b>	<b>382,937</b>	<b>63,919</b>	<b>64,337</b>	<b>419</b>	<b>0.7%</b>
Running Costs	5,535	922	860	(63)	(6.8%)
Reserves	3,866	356	0	(356)	(100.0%)
<b>Total Mandate</b>	<b>392,338</b>	<b>65,197</b>	<b>65,197</b>	<b>(0)</b>	<b>(0.0%)</b>
Target Surplus	9,052	1,508.667	0	(1,509)	(100.0%)
<b>Total</b>	<b>401,390</b>	<b>66,706</b>	<b>65,197</b>	<b>(1,509)</b>	<b>(2.3%)</b>

The table below details the forecast out turn by service line at Month 2.

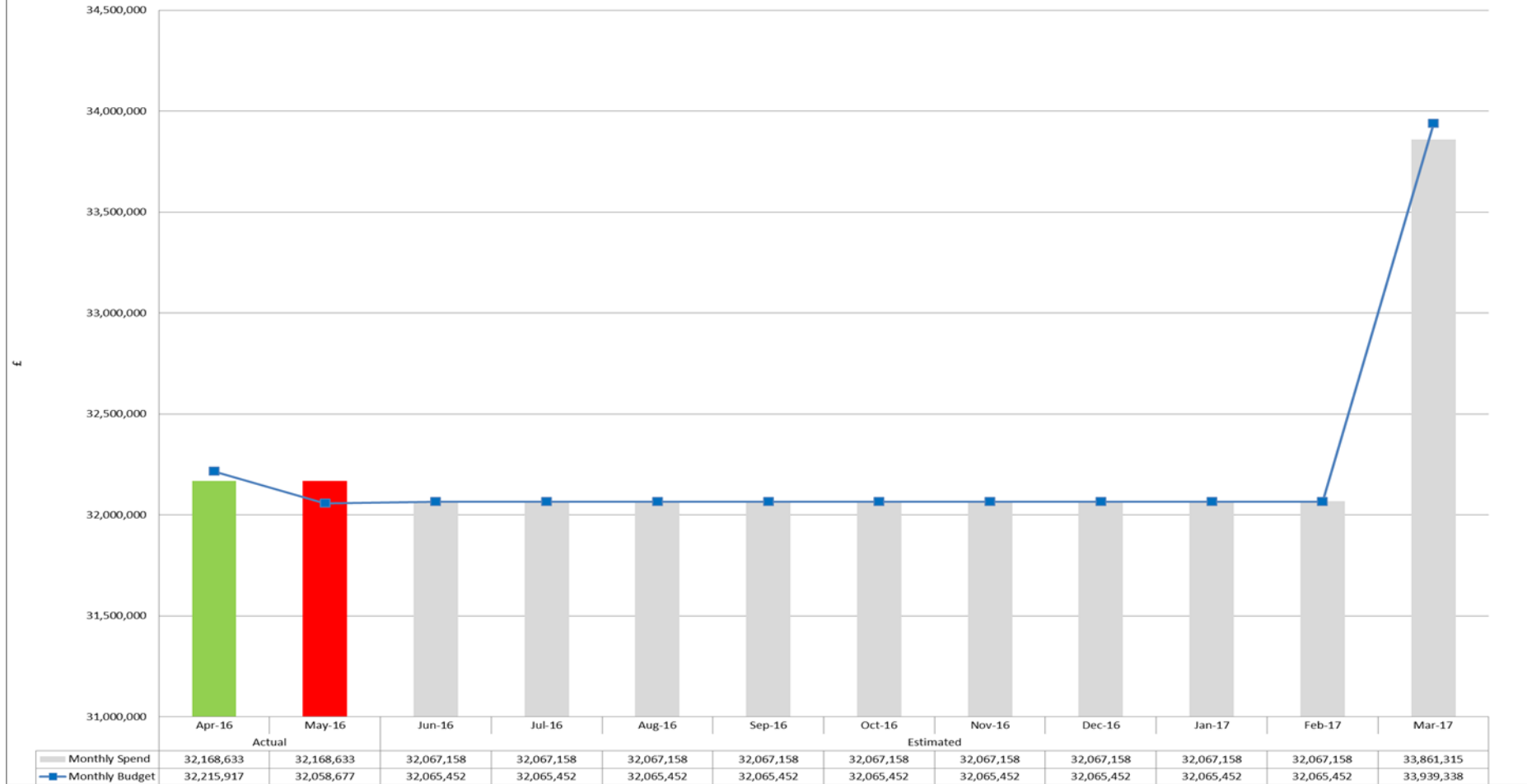
	Annual Plan £'000	Yr End Forecast £'000	Yr End Variance Total £'000 o(u)	Yr End Variance Recurrent £'000 o(u)	Yr End Variance Non Recurrent £'000 o(u)	Yr End Variance %
Acute Services	190,491	190,282	(210)	(450)	241	(0.11%)
Mental Health Services	35,366	35,423	56	0	56	0.16%
Community Services	36,947	36,913	(34)	5	(39)	(0.09%)
Continuing Care/FNC	13,899	13,987	88	0	88	0.63%
Delegated Primary Care	34,477	34,477	0	0	0	0.00%
Prescribing & Quality	51,184	51,370	185	93	92	0.36%
Other Programme	20,572	22,274	1,702	6,886	(5,184)	8.27%
<b>Total Programme</b>	<b>382,937</b>	<b>384,726</b>	<b>1,788</b>	<b>6,533</b>	<b>(4,745)</b>	<b>0.47%</b>
Running Costs	5,535	5,535	0	0	0	0.00%
Reserves	3,866	2,077	(1,788)	(1,788)	0	(46.26%)
<b>Total Mandate</b>	<b>392,338</b>	<b>392,338</b>	<b>0</b>	<b>4,745</b>	<b>(4,745)</b>	<b>0.00%</b>
Target Surplus	9,052	0	(9,052)	(9,052)	0	(100.00%)
<b>Total</b>	<b>401,390</b>	<b>392,338</b>	<b>(9,052)</b>	<b>(4,307)</b>	<b>(4,745)</b>	<b>(2.26%)</b>

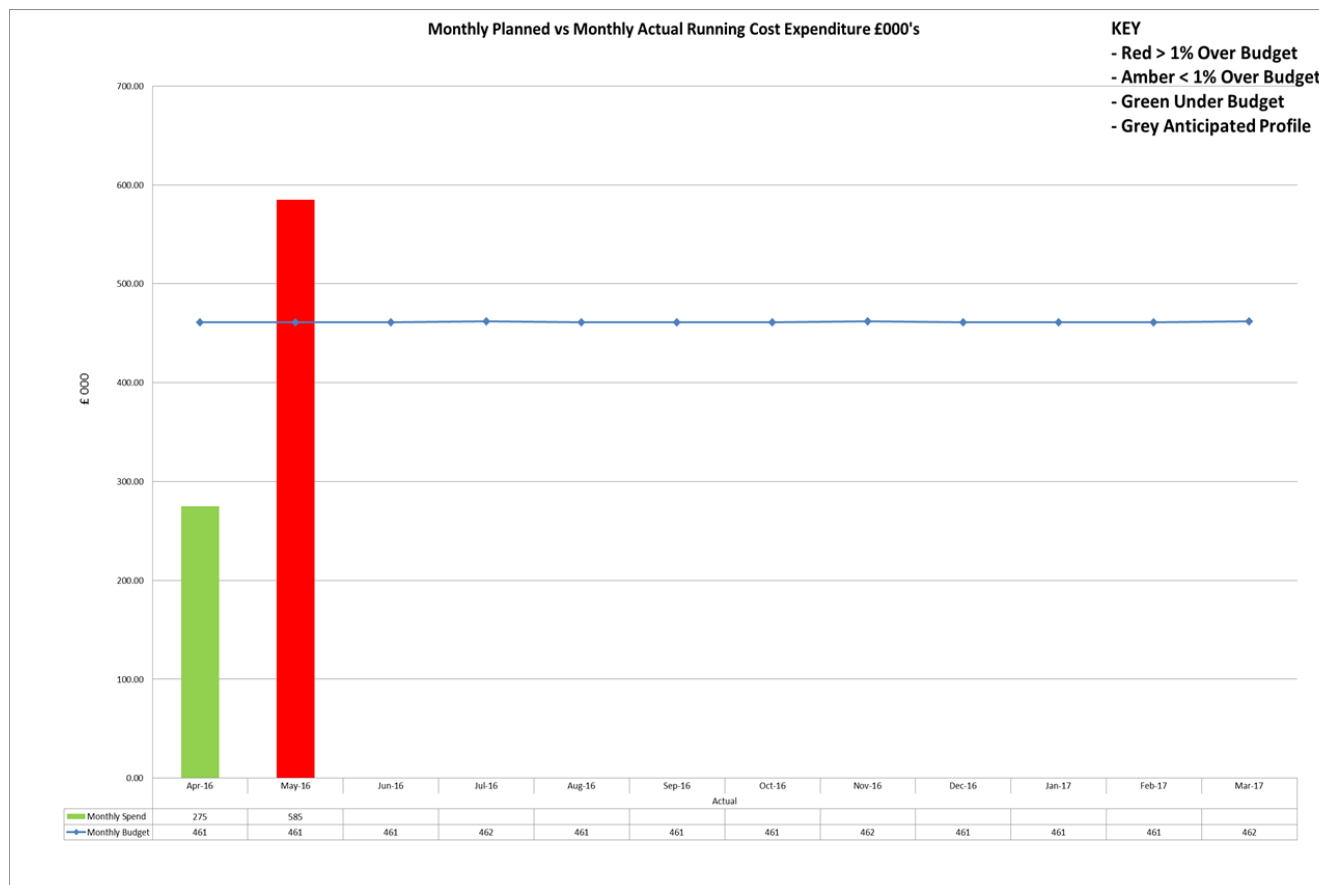
- To achieve the target surplus the CCG has utilised all of the Contingency Reserve, £1.780m. For 18/19 the CCG will need to reinstate the Contingency and this will be a first call on growth monies.
- The CCG is required to maintain a recurrent underlying surplus of 2% of its allocation (£7.551m as per Financial Plan). The year end position calculated in the monthly submission to NHSE delivers 1.95% as a result of the Primary Care Delegated budgets being included. This NHSE calculation is incorrect as 1% surplus does not have to be made on the Delegated Primary Care Budgets.

The table on the following page highlights movements in the forecast between months 1 and 2 although the basis for month one was assumed as breakeven:

### Monthly Planned vs Monthly Actual Programme Expenditure

- KEY**
- Red > 1% Over Budget
  - Amber < 1% Over Budget
  - Green Under Budget
  - Grey Anticipated Profile





- The movement in spend between April and May is expected as there are missing accruals in the April position. This is due to the focus of finance work being the completion of the year-end accounts during April. Movements in future months will be considerably lower.
- Running costs historically have reported a stable position from M3 onwards and this is anticipated to continue through to year end. Traditionally the last 3 months of the financial year see a proportionally higher spend per month but overall a breakeven position is forecast at year end.

## 2. Delegated Primary Care

The Committee noted a small improvement in the QIPP Programme FOT as at Month 10.

Delegated Primary Care Allocations for 2017/18 as at month 02 are £34.825m. The forecast outturn is £34.825m delivering a breakeven position.

The planning metrics for 2017/18 are as follows;

- Contingency delivered across all expenditure areas of 0.5%
- Non Recurrent Transformation Fund of 1%. The CCG is not required to deliver a surplus of 1% on their GP Services Allocations. The table below shows the revised forecast for month 02:

	Annual Budget	FOT M02	Var
	£'000s	£'000s	£'000s
General Practice GMS	21,002	21,002	0
General Practice PMS	1,809	1,809	0
Other list base service AMPS	2,298	2,298	0
Premises	2,684	2,684	0
Premises Other	90	90	0
Enhanced Services	845	845	0
QOF	3,622	3,622	0
Other PCO ie Sickness, Maternity etc	606	606	0
PMS Premium *	494	494	0
Other GP Services	853	853	0
Contingency 0.5%*	174	174	0
Reserve 1%*	348	348	0
<b>Total</b>	<b>34,825</b>	<b>34,825</b>	<b>0</b>

\*budgets being committed non recurrently pending a Q2 budget review.

### 3. QIPP

The key points to note are as follows:

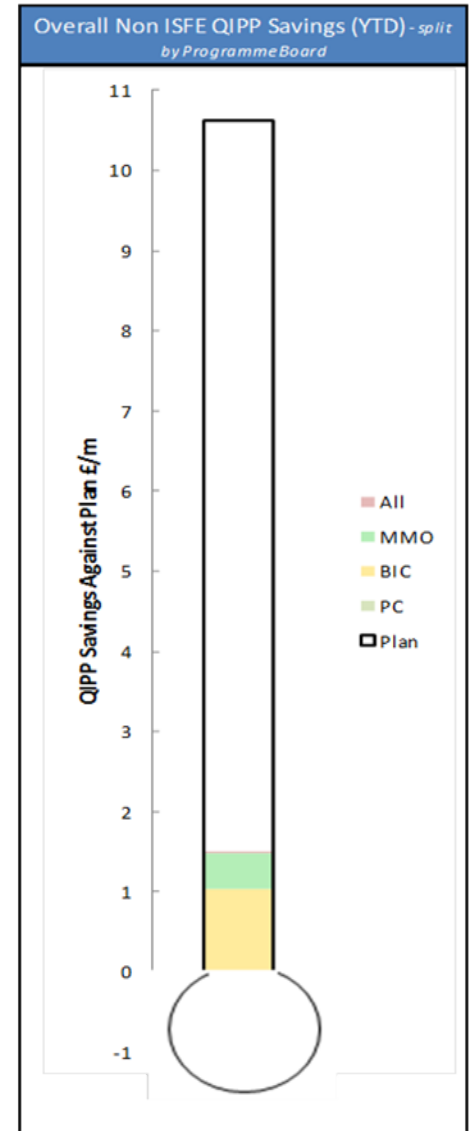
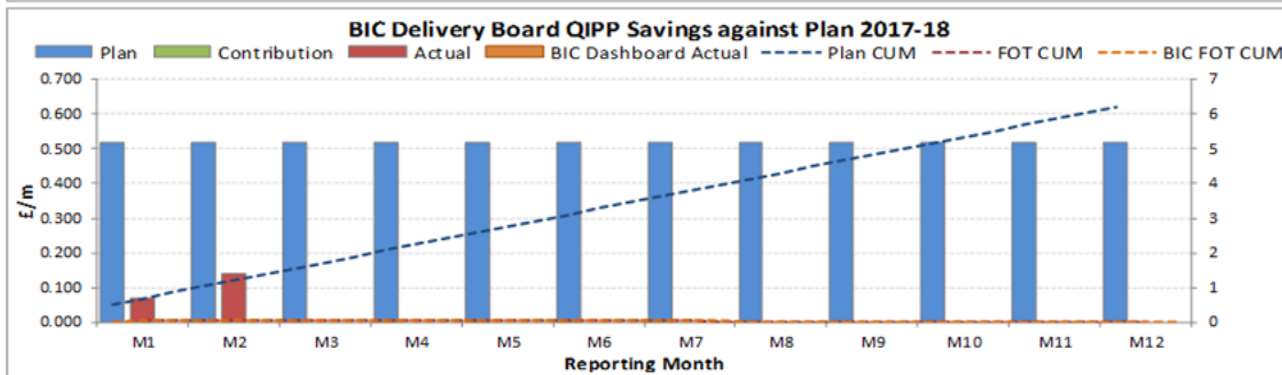
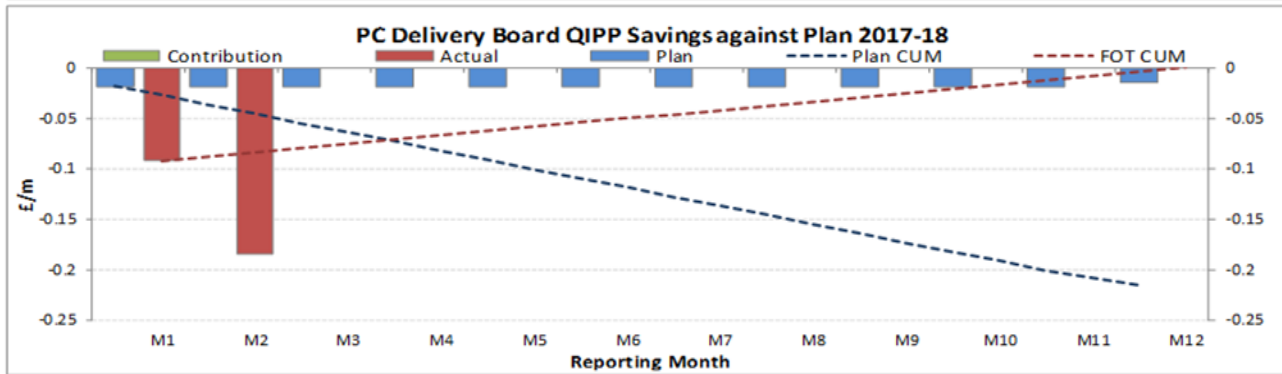
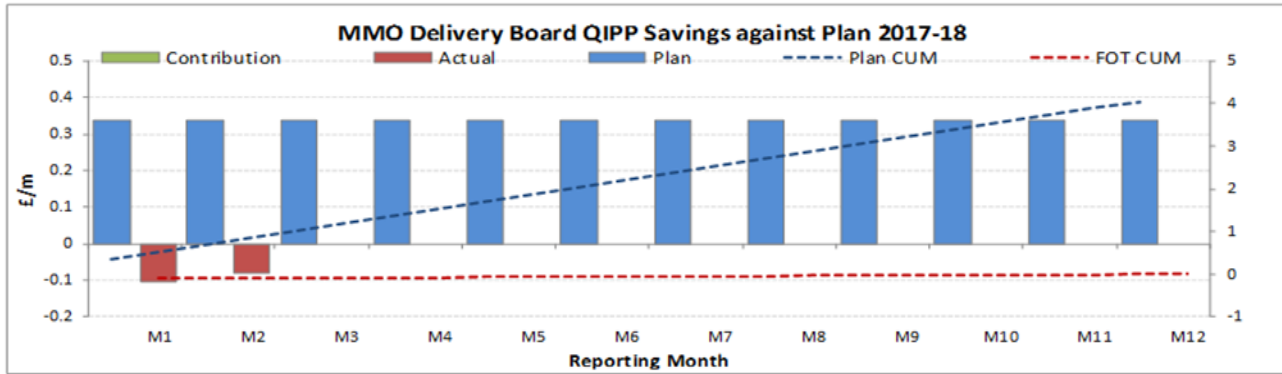
- The CCG target for QIPP for 17/18 is £10.62m.
- The QIPP plan currently has £2.018m in non contracted of which £616k has identified plans.
- £105k has been identified on a recurrent basis which will be reported in Month 3 as well as a further £108k on a non recurrent basis relating to unutilised sanctions.
- A Deep Dive into Budgets at the end of Q1 is likely to identify further QIPP to contribute against the non contracted QIPP.
- Reporting to NHSE requires QIPP to be split between Transactional QIPP and Transformational QIPP. The table below details the split between categories:

	Annual Plan £'m	FOT £m	Variance o(u) £'m	YTD Plan £'m	YTD Actual £'m	Variance o(u) £'m
Transactional	4.05	4.05	0	0.68	0.68	0
Transformational	6.56	6.56	0	1.77	1.77	0
Unallocated	0	0	0	0	0	0
<b>Total</b>	<b>10.61</b>	<b>10.61</b>	<b>0</b>	<b>2.45</b>	<b>2.45</b>	<b>0</b>

# QIPP Programme Delivery Board

Source: Annual Non ISFE Plan, Monthly Project Leads Updates and validated figures from Non ISFE Finance Return

Mth 2 - May 17/18



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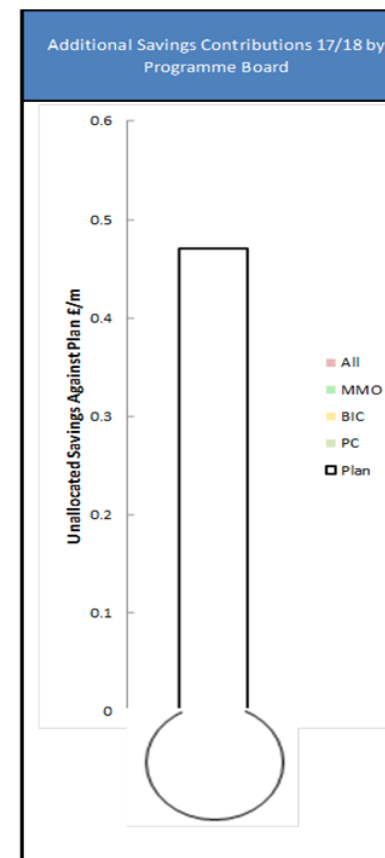


**QIPP Programme Delivery Board**

**Mth 2 - May 17/18**

Source : Annual Non ISFE Plan, Monthly Project Leads Updates and validated figures from Non ISFE Finance Return

Project ID	Description	Annual Plan	YTD Plan	YTD (Non ISFE)	Variance from Plan YTD	FOT (Non ISFE)	FOT Variance from Annual Plan	May YTD Non ISFE diff from Prog Brd	May FOT Non ISFE diff from Prog Brd
17/18-1	Chest Pain Tariff	0.240	0.040	0.040	0.000	0.240	0.000	0.040	0.000
17/18-2	Lucentis Tariff	0.583	0.097	0.097	0.000	0.583	0.000	0.097	0.000
17/18-3	Walking for Health	0.038	0.006	0.006	0.000	0.038	0.000	0.000	0.000
17/18-4	Therapy Service Review (R&R Team)	0.071	0.012	0.012	0.000	0.071	0.000	0.000	0.000
17/18-5	CHC Efficiencies	0.135	0.023	0.023	0.000	0.135	0.000	0.000	0.000
17/18-6	Prescribing Efficiencies	2.050	0.342	0.342	0.000	2.050	0.000	0.216	0.000
17/18-7	Estates Voids	0.100	0.017	0.017	0.000	0.100	0.000	0.017	0.000
17/18-8	EPP	0.300	0.050	0.050	0.000	0.300	0.000	0.050	0.000
17/18-9	Practice Transformation Support - Investment	-0.500	-0.084	-0.084	0.000	-0.500	0.000	0.000	0.000
17/18-10	Community Investment	-0.600	-0.100	-0.100	0.000	-0.600	0.000	0.000	0.000
17/18-11	NEPTS	0.403	0.067	0.067	0.000	0.403	0.000	0.000	0.000
17/18-12	MSK - Investment	-2.226	-0.372	-0.372	0.000	-2.226	0.000	0.000	0.000
17/18-13	Running Costs	0.100	0.017	0.017	0.000	0.100	0.000	0.000	0.000
17/18-14	MSK Indep. Physios	0.155	0.026	0.026	0.000	0.155	0.000	0.000	0.000
17/18-15	MSK Acute	0.885	0.148	0.148	0.000	0.885	0.000	0.148	0.000
17/18-16	MSK OCAS	0.311	0.052	0.052	0.000	0.311	0.000	0.000	0.000
17/18-17	MSK Community Physio	0.926	0.154	0.154	0.000	0.926	0.000	0.154	0.000
17/18-18	GP Extended Access	0.385	0.064	0.064	0.000	0.385	0.000	0.064	0.000
17/18-19	Dementia (Rubicon C22 Changes) £	0.200	0.033	0.033	0.000	0.200	0.000	0.033	0.000
17/18-20	Paeds NEL	0.397	0.066	0.066	0.000	0.397	0.000	0.066	0.000
17/18-21	Care closer to home	3.690	0.615	0.615	0.000	3.690	0.000	0.615	0.000
17/18-22	EOL	0.200	0.033	0.033	0.000	0.200	0.000	0.000	0.000
17/18-23	Mental Health (surplus 1)	0.169	0.028	0.028	0.000	0.169	0.000	0.000	0.000
17/18-24	Mental Health (surplus 2)	0.277	0.046	0.046	0.000	0.277	0.000	0.000	0.000
17/18-25	Other Community Physio	0.041	0.007	0.007	0.000	0.041	0.000	0.000	0.000
17/18-26	Robotics	0.051	0.008	0.008	0.000	0.051	0.000	0.000	0.000
17/18-27	Care closer to home (stretch)	0.416	0.069	0.069	0.000	0.416	0.000	0.069	0.000
17/18-28	Planned /unplanned Mental Health in acute £	0.148	0.025	0.025	0.000	0.148	0.000	0.025	0.000
17/18-29	Dementia Pathway Review £	0.200	0.033	0.033	0.000	0.200	0.000	0.033	0.000
17/18-55	TWIRL	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
17/18-97	Contract Efficiencies incl NCAs	0.500	0.083	0.083	0.000	0.500	0.000	0.083	0.000
17/18-98	Primary Care Stretch	0.500	0.083	0.083	0.000	0.500	0.000	0.083	0.000
17/18-99	2017/18 Budget	0.470	0.078	0.078	0.000	0.470	0.000	0.078	0.470
<b>Grand Total :</b>		<b>10.615</b>	<b>1.767</b>	<b>1.767</b>	<b>0.000</b>	<b>10.615</b>	<b>0.000</b>	<b>1.872</b>	<b>0.470</b>



Modernisation and Medicines Optimisation	Primary Care
Better Integrated Care	Exec/All
Closed Projects - for information	

#### 4. PERFORMANCE

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

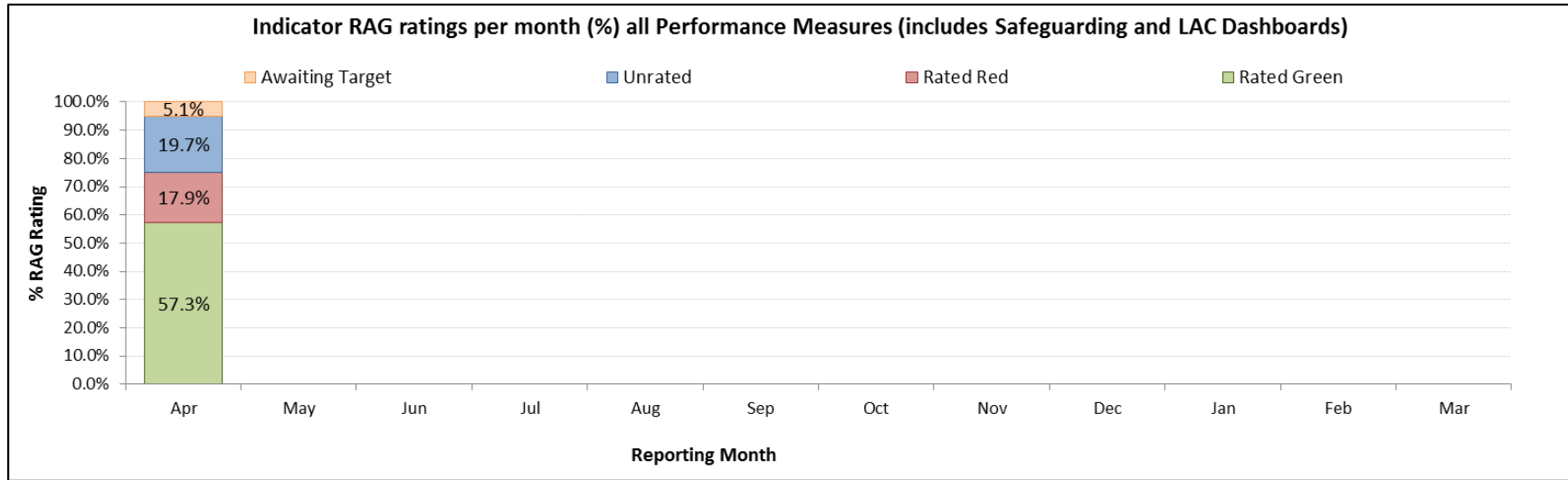
##### Executive Summary - Overview

Apr-17

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	No Submission (blank)	Previous Mth	Target TBC or n/a *	Total
NHS Constitution	N/A	13	N/A	10	N/A	1	N/A	0	24
Outcomes Framework	N/A	9	N/A	5	N/A	12	N/A	0	26
Mental Health	N/A	24	N/A	2	N/A	8	N/A	0	34
Safeguarding - RWT	N/A	7	N/A	4	N/A	2	N/A	0	13
Looked After Children (LAC)	N/A	0	N/A	0	N/A	0	N/A	6	6
Safeguarding - BCP	N/A	14	N/A	0	N/A	0	N/A	0	14
<b>Totals</b>	<b>0</b>	<b>67</b>	<b>0</b>	<b>21</b>	<b>0</b>	<b>23</b>	<b>0</b>	<b>6</b>	<b>117</b>

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	No Submission (blank)	Previous Mth:	Target TBC or n/a *
NHS Constitution	-	54%	-	42%	-	4%	-	0%
Outcomes Framework	-	35%	-	19%	-	46%	-	0%
Mental Health	-	71%	-	6%	-	24%	-	0%
Safeguarding - RWT	-	54%	-	31%	-	15%	-	0%
Looked After Children (LAC)	-	0%	-	0%	-	0%	-	100%
Safeguarding - BCP	-	100%	-	0%	-	0%	-	0%
<b>Totals</b>	<b>0%</b>	<b>57%</b>	<b>0%</b>	<b>18%</b>	<b>0%</b>	<b>20%</b>	<b>0%</b>	<b>5%</b>

\* Note : Performance for Looked After Children (LAC) has been included on the Dashboard section of the report for information only as currently does not have targets or thresholds applied to the indicators.



\*Copy of 17/18 Performance Indicators and Dashboards available as Appendix

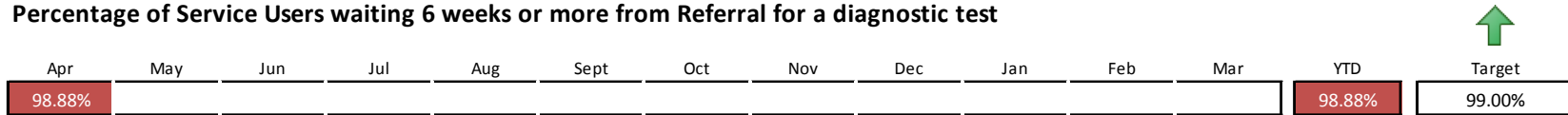
Exception highlights were as follows;

Indicator Ref:	Title and Narrative	Direction of Travel / Yr End Target
	<b>Royal Wolverhampton Hospital NHS Trust (RWT)</b>	

**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
RWT_EB3	<p>The performance data for headline Referral to Treatment (RTT - 18 weeks) Incompletes was not reported on the April SQPR submission, however was verbally provided by the Trust as 91.10%. When compared to the previous years performance, the actual validated National Unify2 submission showed that there has been a decrease in compliance (Apr16 = 91.50% - 2943 breaches out of 34332, Apr17 = 91.07% - 2973 breaches out of 33289) with an overall decrease in the number of patients on the waiting list of 1043 (3.04% decrease). The April performance of 91.07% remains below the 92% National standard but has achieved the proposed 17/18 STF Trajectory for April of 91.03%. Failing specialties include : Urology, Oral Surgery, Trauma &amp; Orthopaedics, Plastic Surgery, Ophthalmology, ENT and General Surgery. Following the resignation of multiple Dermatologists, 2 new locums have been recruited to support the service which is currently performing at 96.92%, the performance will continue to be monitored to assess the impact of staffing changes. The Trust have confirmed that a Consultant has been recruited with special interest in Magnetic Resonance Imaging and Computed Tomography (MRI/CT) scans that will assist with reducing diagnostic waiting times and therefore assist the 18 weeks performance. There has been a 5.37% increase in the number of Ophthalmology waiters due to capacity issues at Shrewsbury and Telford NHS Trust and this has been raised with NHSE as is impacting on the Royal Wolverhampton Trusts capacity and specialty performance (Mar17 = 90.73%, Apr17 = 89.94%). Shrewsbury and Telford NHS Trust have confirmed the following services are currently closed to new referrals : Neurology (a 6 month contract is in place with the Royal Wolverhampton NHS Trust), Spinal Services (one consultant therefore minimal disruption) and three sub-specialities of Ophthalmology (Glaucoma, General Ophthalmology and Adult Squint).</p> <p>The Trust has significantly reduced the backlog of incompletes within threshold (to prevent further patients breaching), however those that remain over threshold continue to impact on monthly performance. 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 confirmed number of patients reported over 52 weeks at the end of April is 7 (all Orthodontics patients) and remains ahead of target against the recovery action plan trajectory of 14 by month end. Additional sessions have continued during May to ensure that performance remains within the recovery trajectory and the Trust are confident that the 52 week waiters will be clear by end of June. Early indications are that the May performance has seen an increase to 91.50% and is above the STF trajectory for M2.</p>													

**Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test**



The performance for Diagnostic Tests has failed to achieve the 99% target since October 2016, with the April performance reporting at 98.88% (61 breaches out of 5438). All diagnostic test areas were at 100% in April with the exception of Computed Tomography (CT = 25 breaches out of 744), Magnetic Resonance Imaging (MRI = 32 breaches out of 1074) and Non-Obstetric Ultrasound (4 breaches out of 1435). The Trust have confirmed that there are 2 primary issues for achieving target -

The Trust sole Cardiac Consultant commenced Maternity leave in November and a locum consultant recruited, however has been unable to maintain the substantive consultants workload. The Trust attempted further recruitment but this has so far been unsuccessful.

The average number of new referrals has increased (from an average of 30, increasing to 70 per month) following the introduction of new NICE guidelines. The Trust confirmed at the Clinical Quality Review Meeting (CQRM) meeting held in May that there was a backlog of descriptive imaging reports (which are sent with a copy of the image scans). The Trust have approached an external provider to clear the backlog with a trajectory of end of July for compliance. Two radiographers have been employed to work through the backlog of scans and are on track to clear the backlog by the end of July. The Radiology Department continues to work closely with the Cardiac Directorate to utilise scan capacity. The Radiographers are aware of reporting issues and will flag any cases if they are deemed clinically more urgent - categories are : Inpatient (same day), Routine (within 6 weeks), Urgent (within 5 days), 62 Day Target (within 5 days) and Soon (within 2 weeks). Outsourcing of scans has been investigated, however as specialised scans require a consultant to be present during consultations this is not an option for all referrals. A mobile CT scanner remains on site and routine scans are being displaced in order to create specialist capacity within the Radiology Department. As a Commissioner, the April performance calculates as 98.56% (47 breaches out of 3256) of which 37 relate to the Royal Wolverhampton NHS Trust, 10 to other Providers (compared to 5 breaches at end of March17):

Cystoscopy - 1 x Walsall Healthcare NHS Trust

MRI - 2 x Birmingham Women's & Children's NHS Foundation Trust, 1 x Nuffield Wolverhampton, 1 x Dudley Group NHS Foundation Trust

Non Obstetric Ultrasound - 3 x Dudley Group NHS Foundation Trust

Urodynamic - 2 x University Hospitals Birmingham NHS Foundation Trust

Early indications are that the Royal Wolverhampton NHS Trust performance for May has seen an increase to 99.06% and is therefore GREEN.

RWT\_EB4

**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
92.52%												92.52%	95.00%

RWT\_EB5

The April performance (92.52%) has failed to achieve the National target (Type 1 and All Types) of 95%, however has achieved the proposed 17/18 STF Trajectory for April of 90.00%. The percentage of patients seen within 4 hrs has seen a 1.28% increase from the previous month and is the highest performance achieved since September 2016. The performance can be split into the following : Emergency Department (New Cross) - 87.36%, Walk-In Centre -100%, Cannock Minor Injury Unit (MIU) - 100% and Vocare - 92.52%. When compared to the previous year's compliance, there has been an improvement in performance (Apr16 - 85.08%, Apr17 - 92.52%). The Trust and CCG continue to hold Urgent Care teleconferences (Exec to Exec) three times a week and the A&E Delivery Board meetings to review progress and manage performance. A revised trajectory has been submitted and is awaiting approval from NHS Improvement (NHSI) which would provide a staggered recovery to meet national recovery trajectory of 91% by September 2017 and full compliance of the 95% target by March 2018. The Group Manager for Emergency Care at the Trust has provided a summary of recommendations and actions from the Matthew Cooke report to the CCG Quality and Safety Committee. This included identification of risks associated with Locum usage, expansion and clinically focussed Human Factors Training, nursing and medical capacity gaps. The A&E performance continues to be discussed at the monthly CQRM and CRM meetings, as part of the CCG Assurance Call Agenda with NHS England, the A&E Delivery Boards and as part of the Quality Requirements and National Operational Standards contract for 2017/18. Early indications are that the May performance (2017/18) has seen an increase to 94.12% which is the highest performance level since August 2015.

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

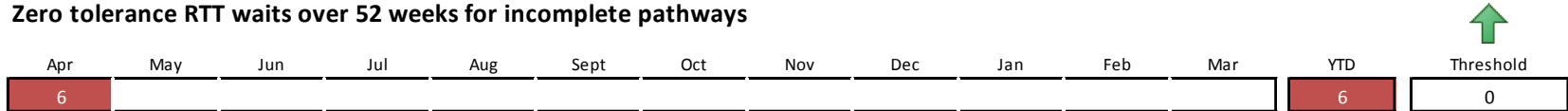


Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
77.40%												77.40%	85.00%

RWT\_EB12

The performance for the 62 Day from GP Referral to 1st definitive treatment has failed to achieve the 85% target (77.40%) and has only achieved standard once since December 2016. The Trust have since confirmed via the Integrated Quality and Performance Report that there were 20 patients that breached target during April (4 x tertiary referrals, 9 x capacity issues, 3 x patient initiated and 4 x complex pathways). Of the tertiary referrals, 2 referrals were received after day 62 of the patient pathway and therefore had already breached standard. Analysis by Cancer site confirms the breaches are relating to : Urology (4 breaches out of 17.5 - 77.14%), Colorectal (3 breaches out of 7 - 57.14%), Head & Neck (1 breaches out of 4.5 - 77.78%), Upper GI (2 breach out of 8 - 75.00%), Gynaecology (3.5 breaches out of 7.5 - 53.33% and Skin (2 breaches out of 9.5 - 78.95%). Other cancer site performance reported as follows : Lung (0 breaches out of 2 - 100%), Haematology (0 out of 3 - 100%) and Breast (2 out of 16 - 87.50%). The Trust have confirmed that excluding tertiary referrals performance for April reports at 77.94%. Exec level discussions have taken place between the Royal Wolverhampton NHS Trust and The Dudley Group of Hospitals regarding late tertiary referrals, however negotiations and requests to change to the current system have been unsuccessful as would also directly impact on the Dudley performance standards. Validated figures are received after the SQPR submission deadline as the final cancer figures are uploaded nationally 6 weeks after month end and April performance has been confirmed as 74.10% (21.5 patient breaching target out of 83) and therefore remains RED. Performance is discussed at the CQRM and CRM meetings with the Trust who confirm that they have been in discussions with NHSI regarding a recovery trajectory to achieve only 83% by year end, but this is yet to be formally agreed.

### Zero tolerance RTT waits over 52 weeks for incomplete pathways



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 April, 6 patients were recorded as waiting over 52 weeks, however the validated National Unify2 data has since confirmed that were 7 Orthodontic patients waiting over 52 week. 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 have confirmed that the original Orthodontic long waiters back log is nearing completion with the exception of 1 complex case who has been scheduled to be seen in May. The Trust recovery trajectory is set to clear all remaining long waiters by the end of June and they are confident that this will be achieved. At the CQRM meeting held in May, the April 2017 total remaining 52 week waiters was confirmed as 7, with the expectation that May will report 5 remaining patients. As a commissioner the CCG have the following breaches :

1 x Trauma & Orthopaedic patient waiting over 52 weeks at the Royal Orthopaedic Hospital (ROH Birmingham) who is classified as a Spinal Deformity patient and therefore a specialised commissioning responsibility. The co-ordinating commissioner (Birmingham Cross City CCG) have confirmed that ROH are working with Specialised Commissioning to support issues around spinal surgery.

1 x Other specialty waiting at University Hospital of North Midlands. 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 52 week waiters performance remains as part of the Quality requirements Operational Standards for 2017/18 with the threshold remaining at zero per month.

RWT\_EBS4

**Delayed Transfers - % occupied bed days - to exclude social care delays**



Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Threshold
1.75%												1.75%	2.00%

The Delayed Transfers of Care (DTOC) indicator is based on the proportion of delays by occupied bed days (excluding Social Care) and has achieved the 2.0% threshold in-month (1.75%). The Trust have confirmed via the Integrated Quality and Performance Report (published and available from the Trust Public website) the total performance (including social care) is 5.7%. The Trust have confirmed that there were 38 delay breaches in April, of which 12 were Stafford patients and the issue of delays was discussed at the April CQRM meeting as Stafford delays continuing to have significant impact on performance with disproportionately longer stays. The Stafford and Cannock CCG's have formally responded to NHSE regarding improving the DTOC position and have identified the following actions :

- The CCG's will be contacting all main Trusts and will provide contact details for their Urgent Care Team for escalations of Delay issues
- On a bi-monthly basis, a representative from the Stafford/Cannock CCG will attend the Wolverhampton A&E Delivery Board. The Trust have indicated the following delay reasons for April:

- 36.5% - Delay Awaiting Assessment (prev 39.5% - decrease)
- 12.2% - Delay awaiting further NHS Care (prev 18.4% - decrease)
- 17.4% - Delay awaiting domiciliary package (prev 21.1% - decrease)
- 15.7% - Delay awaiting family choice (prev 6.4% - increase)
- 4.3% - Delay awaiting equipment/adaptations (prev 1.8% - increase)
- 3.5% - Delay awaiting public funding (prev 0.9% - increase)

Delayed Transfers of Care continues to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. A threshold of 3.5% by September 2017 (combined NHS and Social Care related delays) has been agreed between the Royal Wolverhampton Hospital and Local Authority (stretched from 4.9% to 3.5%). A set of actions have been agreed to support this work and to achieve the threshold by September 2017.

Early indications are that the May performance is 2.1% and remains below the 2.5% threshold (excluding Social Care).

RWT\_LQR3



**E-Referral – ASI rates**

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Threshold
													10.00%

Performance for this indicator was not submitted for April as verified data was unavailable at time of submission due to NHSE publication deadlines. However, this has been highlighted as an exception report as the E-Referral indicator has failed to achieve the 10% throughout 2016-17 and performance has since been confirmed by the Trust for April as 34.66%.

Analysis of the year on year performance shows that the M1 performance relates to a lower number of records (16/17 denominator = 4889, 17/18 denominator = 3722 and a reduction of 1167), a higher numerator value (16/17 numerator = 701, 17/18 numerator = 1290) and a performance below that of the same period in 2016/17 (14.34%). The Trust have signed up to start the Paper Switch Off CQUIN project which relates to routine appointments (not urgent) from July 2017 with a 9 month timeline, however concerns have been raised as early achievers to the project could receive additional referrals from surrounding CCGs which will increase their ASI rate more than planned. Part of the paper switch off project is to poll out on the E-Referral System (e-RS) to the same waits that providers have for paper referral waits, however as this can impact on the Referral to Treatment performance (RTT 18 Weeks) and contravenes the RTT targets. NHS England (NHSE) are to query which target should have more weight and will advise the CCG accordingly. Advice & guidance is seen as a key element of using e-RS successfully and the improved functionality encourages referring clinicians to use the system more efficiently. If the Royal Wolverhampton NHS Trust fail to achieve the paper switch off project then potentially will lose the CQUIN payment of £12million (over 2 years).

RWT\_LQR12

## 5. RISK and MITIGATION

Risks	Potential Risk Value Mth01	Full Risk Value £m	Probability of risk being realised %	Potential Risk Value £m	Proportion of Total %	Commentary
CCGs						
Acute SLAs	0.00	2.00	70.00%	1.40	29.82%	risk of in year overperformance
Community SLAs	0.00			0.00	0.00%	
Mental Health SLAs	0.00			0.00	0.00%	
Continuing Care SLAs	0.00			0.00	0.00%	
QIPP Under-Delivery	0.00	2.47	60.00%	1.48	31.60%	risk of slippage on non contracted QIPP
Performance Issues	0.00			0.00	0.00%	
Primary Care	0.00			0.00	0.00%	
Prescribing	0.00	0.70	80.00%	0.56	11.93%	risk of overspend materialising
Running Costs	0.00			0.00	0.00%	
Other Risks	0.00	1.80	69.50%	1.25	26.65%	£500k risk on IR allocation deduction materialising and £1.3m on BCF (LA budgets)
<b>TOTAL RISKS</b>	<b>0.00</b>	<b>6.97</b>		<b>4.69</b>	<b>100.00%</b>	

- The table above details the current assessment of risk for the CCG; a gross risk of £6.97m but risk assessed to £4.69m.

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

Risks	Potential Risk Value Mth01	Full Risk Value £m	Probability of risk being realised %	Potential Risk Value £m	Proportion of Total %	Commentary
CCGs						
Acute SLAs	0.00	2.00	70.00%	1.40	29.82%	risk of in year overperformance
Community SLAs	0.00			0.00	0.00%	
Mental Health SLAs	0.00			0.00	0.00%	
Continuing Care SLAs	0.00			0.00	0.00%	
QIPP Under-Delivery	0.00	2.47	60.00%	1.48	31.60%	risk of slippage on non contracted QIPP
Performance Issues	0.00			0.00	0.00%	
Primary Care	0.00			0.00	0.00%	
Prescribing	0.00	0.70	80.00%	0.56	11.93%	risk of overspend materialising
Running Costs	0.00			0.00	0.00%	
Other Risks	0.00	1.80	69.50%	1.25	26.65%	£500k risk on IR allocation deduction materialising and £1.3m on BCF (LA budgets)
<b>TOTAL RISKS</b>	<b>0.00</b>	<b>6.97</b>		<b>4.69</b>	<b>100.00%</b>	

## 6. 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.

### Other Risk

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

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

## 7. RECOMMENDATIONS

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

**Name:** Lesley Sawrey  
**Job Title:** Deputy Chief Finance Officer  
**Date:** 28th June 2017

# Appendix 1

## Performance Indicators 17/18

Current Month:

### 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

17/18 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	Yr End		
RWT_EB4	Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test	RWT	99%	98.88%	R	98.88%	R	↑														
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%	92.52%	R	92.52%	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%	90.91%	R	90.91%	R	↓														
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%	94.59%	G	94.59%	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%	94.38%	R	94.38%	R	↓														
RWT_EB9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery	RWT	94%	77.78%	R	77.78%	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	100.00%	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%	100.00%	G	100.00%	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%	77.40%	R	77.40%	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%	94.74%	G	94.74%	G	↑														
RWT_EB51	Mixed sex accommodation breach	RWT	0	0.00	G	0.00	G	↔														
RWT_EB52	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	Mths 1-11 = 3 Mth 12 = 2	4.00	R	4.00	R	↓														
RWT_EB54	Zero tolerance RTT waits over 52 weeks for incomplete pathways	RWT	0	6	R	6	R	↑														
RWT_EB57a	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	RWT	0	33	R	33	R	↑														
RWT_EB57b	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	RWT	0	1	R	1	R	↑														
RWT_EB55	Trolley waits in A&E not longer than 12 hours	RWT	0	0	G	0	G	↔														
RWT_EB56	No urgent operation should be cancelled for a second time	RWT	0	0	G	0	G	↔														
RWTCB_S10C	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE, as defined in Contract Technical Guidance	RWT	95%	95.42%	G	95.42%	G	↓														
RWTCB_S10B	Duty of candour (Note : Yes = Compliance, No = Breach)	RWT	Yes	Yes	G	-	-															
RWTCB_S10D	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	RWT	99.00%	99.84%	G	99.84%	G	↓														
RWTCB_S10E	Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	RWT	95.00%	98.57%	G	98.57%	G	↓														
RWT_LQR1	Electronic discharge summary to be fully completed and dispatched within 24 hours of discharge for all wards excluding assessment units.	RWT	95.00%	91.30%	R	91.30%	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	Q1 - 85% Q2 - 90% Q3 - 90% Q4 - 92.5%	81.94%	R	81.94%	R	↑														
RWT_LQR3	Delayed Transfers - % occupied bed days - to exclude social care delays	RWT	Q1 - 2.5% Q2 - 2.4% Q3 - 2.2% Q4 - 2.0%	1.75%	G	1.75%	G	↓														
RWT_LQR4	Serious incident (SI) reporting – SIs to be reported no later than 2 working days after the date of incident occurrence (as per SI Framework) Exceptions will be considered with Chief Nurse discussions. Note: Date of occurrence is equal to the date, the incident was discovered	RWT	0	0.00	G	0.00	G	↔														
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). To be completed within 3 working days of the incident occurrence date. Note: Date of occurrence is equal to the date, the incident was discovered	RWT	0	0.00	G	0.00	G	↔														
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	0.00	G	↑														
RWT_LQR7	Number of cancelled operations - % of electives	RWT	0.80%	0.35%	G	0.35%	G	↑														

RWT_LQR13	Maternity - Antenatal - % of women booked by 12 weeks and 6 days	RWT	90.00%	92.40%	G	92.40%	G	↑	
RWT_LQR14	Stroke - Percentage of patients who spend at least 90% of their time on a stroke unit	RWT	80.00%	86.67%	G	86.67%	G	↓	
RWT_LQR15	Stroke - Percentage of higher risk TIA cases are assessed and treated within 24 hours	RWT	60.00%	76.60%	G	76.60%	G	↓	
RWT_LQR17	Best practice in Day Surgery - outpatient procedures - % of Day case procedures that are undertaken in an Outpatient setting	RWT	92.50%	99.61%	G	99.61%	G	↑	
RWT_LQR21	Safeguarding – failure to achieve thresholds for specific indicators as detailed in the Combined Safeguarding Dashboard. (Submit : Yes if all Dashboard is compliant, No if breaches)	RWT	Yes	No	R	-	-	EVALUATE	
RWT_LQR28	All Staff Hand Hygiene Compliance	RWT	95.00%	90.42%	R	90.42%	R	EVALUATE	
RWT_LQR29	Infection Prevention Training Level 2	RWT	95.00%	94.21%	R	94.21%	R	EVALUATE	
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%	96.57%	G	96.57%	G	↓	
BCPFT_EB54	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	-	-	EVALUATE	
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	100.00%	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%	95.83%	G	95.83%	G	↑	
BCPFT_EH2	Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who are treated within 18 weeks of referral	BCP	95.00%	100.00%	G	100.00%	G	→	
BCPFT_EB51	Mixed sex accommodation breach	BCP	0	0	G	0	G	→	
BCPFT_EB53	Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialities on CPA who were followed up within 7 days of discharge from psychiatric in-patient care*	BCP	95.00%	96.57%	G	96.57%	G	↓	
BCPFT_LQGE01b	Percentage of inpatients with a Crisis Management plan on discharge from secondary care. (NB: exclusions apply to patients who discharge themselves against clinical advice or who are AWOL)	BCP	100.00%	94.29%	R	94.29%	R	↓	
BCPFT_LQGE09	Evidence of using HONOS: Proportion of patients with a HONOS score	BCP	95.00%	96.07%	G	96.07%	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%	5.12%	G	5.12%	G	↑	
BCPFT_LQGE12a	% of Crisis assessments carried out within 4 hours (Wolverhampton Psychiatric Liaison Service Emergency)	BCP	95.00%	96.69%	G	96.69%	G	EVALUATE	
BCPFT_LQGE13a	% of Urgent assessments carried out within 48 hours (Wolverhampton Psychiatric Liaison Service)	BCP	85.00%	91.67%	G	91.67%	G	EVALUATE	
BCPFT_LQGE14b	% of Routine assessments carried out within 8 weeks (Wolverhampton Psychiatric Liaison Service Routine Referral)	BCP	85.00%	98.04%	G	98.04%	G	EVALUATE	
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. Day one commences as of reporting date). 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	100.00%	G	→	
BCPFT_LQGE17	Provide commissioners with Level 1 (concise) and Level 2 (comprehensive) RCA reports within 60 working days and Level 3 (independent investigation) 6 months from the date the investigation is commissioned as per Serious Incident Framework 2015 page 41. All internal investigations should be supported by a clear investigation management plan.	BCP	100.00%	80.00%	R	80.00%	R	↓	
BCPFT_LQIA01	Percentage of people who are moving to recovery of those who have completed treatment in the reporting period [Target ->50% Sanction: GC9]	BCP	50.00%	51.05%	G	51.05%	G	↓	
BCPFT_LQIA02	75% of people engaged in the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral [Target ->75% Sanction: GC9]	BCP	75.00%	95.83%	G	95.83%	G	↑	
BCPFT_LQIA03	95% of people referred to the Improved Access to Psychological Therapies programme will be treated within 18 weeks of referral [Target ->95%, Sanction: GC9]	BCP	95.00%	100.00%	G	100.00%	G	→	
BCPFT_LQIA05	People who have entered treatment as a proportion of people with anxiety or depression (local prevalence) [Target: Special Rules - 29,880 = 15% of prevalence.	BCP	1.25%	1.50%	G	1.50%	G	↓	
BCPFT_LQCA01	Percentage of children referred who have had initial assessment and treatment appointments within 18 weeks. This indicator will follow the rules applied in the 'improving access to child and adolescent mental health services' reducing waiting times policy and practice guide (including guidance on the 18 weeks referral to treatment standard) in 'Documents Relied Upon'	BCP	90.00%	97.92%	G	97.92%	G	EVALUATE	
BCPFT_LQCA03	Percentage of all referrals from paediatric ward/s for self-harm assessed within 12 working hours of referral	BCP	95.00%	100.00%	G	100.00%	G	EVALUATE	
BCPFT_LQCA04	Every person presenting at A&E with crisis seen within 4 hours. The clock starts when A&E make the referral to crisis.	BCP	100.00%	100.00%	G	100.00%	G	EVALUATE	

**Additional Information - Dashboards**

Current Month:

**Key:**

(based on if indicator required to be either Higher or Lower than target/threshold)

- ↑ Improved Performance from previous month
- ↓ Decline in Performance from previous month
- Performance has remained the same

**RWT - Safeguarding**

Area	17/18 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												Yr End	
										A	M	J	A	S	O	N	D	J	F	M			
Safeguarding - RWT	RWT_LQSG01	<b>Level 1 training for Safeguarding Children</b> As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 1 Safeguarding Children competence.	RWT	95%	98.57%	G	98.57%	G	↑														
Safeguarding - RWT	RWT_LQSG02	<b>Level 2 training for Safeguarding Children</b> As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of staff that have up to date Level 2 Safeguarding Children competence.	RWT	85%	95.43%	G	95.43%	G	↑														
Safeguarding - RWT	RWT_LQSG03	<b>Level 3 Training for Safeguarding Children</b> As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of staff that have up to date Level 3 Safeguarding Children competence.	RWT	85%	84.25%	R	84.25%	R	↓														
Safeguarding - RWT	RWT_LQSG04	<b>Level 4 training for Safeguarding Children</b> As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of staff that have up to date Level 4 Safeguarding Children competence.	RWT	100%	100.00%	G	100.00%	G	→														
Safeguarding - RWT	RWT_LQSG05	Safeguarding Children training for Board Level for Chief Executive Officers, Trust and Health Board Executive and Non-Executive Directors/members As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document.	RWT	100%	No Data	No Data		No Data															
Safeguarding - RWT	RWT_LQSG06	<b>Level 1 training for Safeguarding Adults</b> As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 1 Safeguarding Adults competence.	RWT	95%	99.61%	G	99.61%	G	↑														
Safeguarding - RWT	RWT_LQSG07	<b>Level 2 training for Safeguarding Adults</b> As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 2 Safeguarding Adults competence.	RWT	85%	95.24%	G	95.24%	G	↑														
Safeguarding - RWT	RWT_LQSG08	<b>Level 3 training for Safeguarding Adults</b> As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 3 Safeguarding Adults competence.	RWT	85%	80.00%	R	80.00%	R	↓														
Safeguarding - RWT	RWT_LQSG09	<b>Level 4 training for Safeguarding Adults</b> As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Named Professionals staff groups.	RWT	100%	100.00%	G	100.00%	G	→														
Safeguarding - RWT	RWT_LQSG10	Safeguarding training for Board Level for Chief Executive Officers, Trust and Health Board Executive and Non-Executive Directors/members As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document.	RWT	100%	No Data	No Data		No Data															
Safeguarding - RWT	RWT_LQSG11	<b>Basic Prevent Awareness Training (level 1&amp;2)</b> as defined in NHS England – Prevent Training and Competencies Framework (2015). Percentage of staff with up to date PREVENT competence.	RWT	95%	24.49%	R	24.49%	R															
Safeguarding - RWT	RWT_LQSG13	<b>Prevent Awareness Training (level 3,4 &amp; 5 )</b> WRAP training as defined in NHS England – Prevent Training and Competencies Framework (2015). % of staff with up to date competencies.	RWT	85%	80.54%	R	81%	R															
Safeguarding - RWT	RWT_LQSG13b	Statutory Organisational Prevent Leads to demonstrate criteria met to achieve competency levels as defined in NHS England – Prevent Training and Competencies Framework (2015). • Attendance at a minimum of 2 NHSE regional Prevent forums each financial year (4 take place) • Evidence of face to face meetings with the channel coordinator and CTU officers • Participate in local or regional multi-agency Prevent forums/Boards when required	RWT	100%	100.00%	G	100.00%	G															
Looked After Children (LAC)	RWT_LQSG15b	Percentage of above requests for IHAs which were completed within statutory timescales.	RWT	n/a	0.00%	n/a	0.00%	n/a															n/a
Looked After Children (LAC)	RWT_LQSG16a	Percentage of completed IHAs which were Quality Assured.	RWT	n/a	100.00%	n/a	100.00%	n/a															n/a
Looked After Children (LAC)	RWT_LQSG17a	Percentage of above requests for RHAs which were completed within statutory timescales.	RWT	n/a	3.23%	n/a	3.23%	n/a	↑														n/a
Looked After Children (LAC)	RWT_LQSG17b	Percentage of completed RHAs which were Quality Assured.	RWT	n/a	100.00%	n/a	100.00%	n/a															n/a
Looked After Children (LAC)	RWT_LQSG18a	Number of requests for Leaving Care Summaries	RWT	n/a	10	n/a	10	n/a															n/a
Looked After Children (LAC)	RWT_LQSG18b	Number of completed Leaving Care Summaries	RWT	n/a	2	n/a	2	n/a															n/a

**BCP - Safeguarding**

Area	17/18 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
Safeguarding - BCP	BCP_IQSG01	<b>Level 1 training for Safeguarding Children</b> As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 1 Safeguarding Children competence. Over a three-year period, staff at level 1 should receive refresher training equivalent to a minimum of 2 hours	BCP	95%	Apr	#VALUE!	96.34%	G		###
Safeguarding - BCP	BCP_IQSG02	<b>Level 2 training for Safeguarding Children</b> As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of staff that have up to date Level 2 Safeguarding Children competence. Over a three-year period, professionals at level 2 should receive refresher training equivalent to a minimum of 3-4 hours.	BCP	85%	96.34%	G	86.35%	G	↓	
Safeguarding - BCP	BCP_IQSG03	<b>Percentage of staff that have up to date Level 3 Safeguarding Children competence.</b> Over a three-year period, professionals should receive refresher training equivalent to a minimum of 6 hours (for those at Level 3 core this equates to a minimum of 2 hours per annum) and a minimum of 12-16 hours (for those at Level 3 requiring specialist knowledge and skill). As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document.	BCP	85%	86.35%	G	90.27%	G	↓	
Safeguarding - BCP	BCP_IQSG04	<b>Level 4 training for Safeguarding Children</b> As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of staff that have up to date Level 4 Safeguarding Children competence. Named professionals should attend a minimum of 24 hours of education, training and learning over a three-year period.	BCP	100%	90.27%	R	100.00%	G	↓	
Safeguarding - BCP	BCP_IQSG05	Safeguarding Children training for Board Level for Chief Executive Officers, Trust and Health Board Executive and Non-Executive Directors/members As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. Percentage of Board Level Executives and non-executives who have up to date Safeguarding Children competence within three months of appointment. This will require a tailored package to be delivered which encompasses level 1, knowledge, skills and competences, as well as Board level specific as identified in this section.	BCP	100%	100.00%	G	100.00%	G	→	
Safeguarding - BCP	BCP_IQSG06	<b>Level 1 training for Safeguarding Adults</b> As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 1 Safeguarding Adults competence. Over a three-year period, staff at level 1 should receive refresher training equivalent to a minimum of 30 minutes.	BCP	95%	100.00%	G	96.39%	G	→	
Safeguarding - BCP	BCP_IQSG07	<b>Level 2 training for Safeguarding Adults</b> As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Percentage of eligible staff that have up to date Level 2 Safeguarding Adults competence. Over a three-year period, individuals at level 2 should receive refresher training equivalent to a minimum of 3-4 hours.	BCP	85%	96.39%	G	89.35%	G	↓	
Safeguarding - BCP	BCP_IQSG08	<b>Level 3 training for Safeguarding Adults</b> As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Individuals moving into a permanent senior level post who have as yet not attained the relevant knowledge, skills and competence required at level 3, it is expected that within a year of appointment additional education will be completed. Percentage of eligible staff that have up to date Level 3 Safeguarding Adults competence. Over a three-year period, professionals should receive refresher training equivalent to a minimum of 6 hours (for those at Level 3 core, this equates to a minimum of 2 hours per annum), a minimum of 12-16 hours (for those at Level 3 requiring specialist knowledge and skill). NB: Existing RAP in place 15/16. This will be carried forward given that the trajectory runs until Dec 2016.	BCP	85%	89.35%	G	90.62%	G	↓	
Safeguarding - BCP	BCP_IQSG09	<b>Level 4 training for Safeguarding Adults</b> As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Named Professionals staff groups. Named Professionals should attend a minimum of 24 hours of education, training and learning over a three-year period. This should include non-clinical knowledge acquisition such as management, appraisal, and supervision training. NB: to be undertaken within three months of appointment.	BCP	100%	90.62%	R	100.00%	G	↑	
Safeguarding - BCP	BCP_IQSG10	Safeguarding training for Board Level for Chief Executive Officers, Trust and Health Board Executive and Non-Executive Directors/members As defined by the Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document. Percentage of eligible members who have up to date Safeguarding Adults competence to be undertaken within three months of appointment. This will require a tailored package to be delivered which encompasses level 1, knowledge, skills and competences, as well as Board level specific as identified in this section.	BCP	100%	100.00%	G	100.00%	G	→	
Safeguarding - BCP	BCP_IQSG11	<b>% Staff with up to date Basic PREVENT Awareness Training Level 1</b> As defined in the NHSE Prevent Training & Competencies Framework Percentage of staff with up to date PREVENT competence. Basic Prevent awareness training should be repeated on a 3 yearly cycle to ensure that individuals are up to date with current procedures and contacts	BCP	85%	100.00%	G	96.68%	G	→	
Safeguarding - BCP	BCP_IQSG12	<b>% Staff with up to date Basic PREVENT Awareness Training Level 2</b> As defined in the NHSE Prevent Training & Competencies Framework Percentage of staff with up to date PREVENT competence. Basic Prevent awareness training should be repeated on a 3 yearly cycle to ensure that individuals are up to date with current procedures and contacts	BCP	85%	96.68%	G	96.68%	G	↑	



Safeguarding - BCP	BCP_IQSG13	<p><b>% Staff with up to date PREVENT Awareness Training Level 3</b>  Level 3 and 4 have to be delivered by trained people as training is more specific. Must take place within 12 months of relevant staff commencing in role.  As defined in the NHSE Prevent Training &amp; Competencies Framework  Percentage of staff with up to date PREVENT competence.  Organisations should issue an update/briefing on Prevent to staff that have attended WRAP annually (or more frequently if required).</p>	BCP	85%	96.68%	G	91.62%	G	↑	
Safeguarding - BCP	BCP_IQSG14	<p><b>% Staff with up to date PREVENT Awareness Training Level 4 and 5</b>  As defined in the NHSE Prevent Training &amp; Competencies Framework  Percentage of staff with up to date PREVENT competence.  Level 3 and 4 have to be delivered by trained people as training is more specific. Must take place within 12 months of relevant staff commencing in role.  Organisations should issue an update/briefing on Prevent to staff that have attended WRAP annually (or more frequently if required).</p>	BCP	85%	91.62%	G	100.00%	G	↑	

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**WOLVERHAMPTON CCG**

**GOVERNING BODY**

11<sup>th</sup> July 2017

Agenda item 13

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<b>Title of Report:</b>	<b>Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 30<sup>th</sup> May 2017</b>
<b>Report of:</b>	Tony Gallagher – Chief Finance Officer
<b>Contact:</b>	Tony Gallagher – Chief Finance Officer
<b>Governing Body Action Required:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>Purpose of Report:</b>	To provide an update of the WCCG Finance and Performance Committee to the Governing Body of the WCCG.
<b>Key Points:</b>	<ul style="list-style-type: none"> <li>• The CCG has submitted its draft accounts for 2016/17. All key national metrics have been met.</li> <li>• Performance information to Month 12 is enclosed. Exceptions are highlighted in the body of the report.</li> </ul>
<b>Recommendations:</b>	<ul style="list-style-type: none"> <li>• <b>Receive</b> and <b>note</b> the information provided in this report.</li> </ul>
<b>Public or Private:</b>	This Report is intended for the public domain.
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	

<ul style="list-style-type: none"> <li>Improving the quality and safety of the services we commission</li> </ul>	<p><u>Ensure on-going safety and performance in the system</u> Continually check, monitor and encourage providers to improve the value for money of patient services ensuring that patients are always at the centre of all our commissioning decisions to ensure the right care is provided at the right time in the right place</p>
<ul style="list-style-type: none"> <li>Reducing Health Inequalities in Wolverhampton</li> </ul>	<p>Improve and develop primary care in Wolverhampton – Delivering a robust financial management service to support 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 Support the delivery new models of care that support care closer to home and improve management of Long Term Conditions by developing robust financial modelling and monitoring in a flexible way to meet the needs of the emerging New Models of Care.</p>
<ul style="list-style-type: none"> <li>System effectiveness delivered within our financial envelope</li> </ul>	<p><u>Proactively drive our contribution to the Black Country STP</u> by playing a leading role in the development and delivery of the Black Country STP Financial model to support material improvement in health and wellbeing for both Wolverhampton residents and the wider Black Country footprint.</p> <p><u>Greater integration of health and social care services across Wolverhampton</u> Work closely with partners finance departments across the City to support the development and delivery of the emerging vision for transformation; including exploring the potential for an ‘Accountable Care System.’</p> <p><u>Continue to meet our Statutory Duties and responsibilities</u> 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</p> <p><u>Deliver improvements in the infrastructure for health and care across Wolverhampton</u> 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.</p>

## 1. FINANCE POSITION

The Committee noted that the final accounts had been submitted and the details of the surplus reported.

## 2. PERFORMANCE

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

### Executive Summary - Overview

Mar-17

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	No Submission (blank)	Previous Mth	Target TBC *	Total
NHS Constitution	11	11	12	13	1	0	0	0	24
Outcomes Framework	7	11	10	8	18	16	2	2	37
Mental Health	22	24	7	7	4	2	0	0	33
<b>Totals</b>	<b>40</b>	<b>46</b>	<b>29</b>	<b>28</b>	<b>23</b>	<b>18</b>	<b>2</b>	<b>2</b>	<b>94</b>

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	No Submission (blank)	Previous Mth:	Target TBC *
NHS Constitution	46%	46%	50%	54%	4%	0%	0%	0%
Outcomes Framework	19%	30%	27%	22%	49%	43%	5%	5%
Mental Health	67%	73%	21%	21%	12%	6%	0%	0%
<b>Totals</b>	<b>43%</b>	<b>49%</b>	<b>31%</b>	<b>30%</b>	<b>24%</b>	<b>19%</b>	<b>2%</b>	<b>2%</b>

\* 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 (2 of which had no data submitted for March 17)

Exception highlights were as follows;

Indicator Ref:	Title and Narrative	Yr End Target / Threshold
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**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%	90.59%		91.00%	90.86%	92.00%

The performance data for headline level Referral To Treatment (RTT) Incompletes has been reported below the 92% target (91.00%) for March. The data for February was not submitted via the deadline, however has since been confirmed as 90.81%, this confirms the Year End performance as 90.85% and below target. When compared to the previous years performance, there has been a decrease in compliance (Mar 15/16 = 92.00% - 2,595 breaches out of 32,455, Mar16/17 = 91.00% - 2,927 breaches out of 32,512) with an overall increase in the number of patients on the waiting list of 57 (0.18% increase). The March data has since been validated via the National Unify2 submission as 91.00% seen within 18 weeks. Failing specialties include : Cardiology, ENT, T&O, General Surgery, Ophthalmology, Plastic Surgery, Oral Surgery and Urology. The Trust have confirmed that the March performance has seen a marginal improvement however has remained under threshold primarily as a result of the Easter period. There has been an increase in the number of Ophthalmology referrals due to capacity issues at Shrewsbury and Telford NHS Trust. This issue has been raised with NHSE as is impacting on the Royal Wolverhampton Trusts capacity and could impact on performance over the next few months. The Dermatology specialty is current achieving standard, however, multiple Dermatologists have submitted resignations which will impact the capacity of the service. Dermatology capacity has been logged on the CRM Action Log and the Trust is discussing options with the Commissioner. Close working with Directorate Managers continues regarding priority bookings for inpatients at 14-17 weeks on the waiting lists. Additional Orthodontic sessions continued throughout April to reduce the 52 week waiters backlog. A proposed staggered STF trajectory for 2017/18 (compliance by end of quarter 1) has been submitted and awaits NHSI signoff. The Trust has significantly reduced the backlog of incompletes within threshold (to prevent further patients breaching), however those that remain over threshold continue to impact on monthly performance. 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 Incompletes headline performance remains as part of the Quality requirements National Operational Standards for 2017/18 with the threshold remaining at 92% with increased focus for RTT in three areas : Referral Diversion, Peer-to-Peer reviews and Musculoskeletal (MSK) Pathway Re-design.

RWT\_EB3

**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%	98.67%	98.56%	98.65%	98.84%	99.00%

The performance for Diagnostic Tests has failed to meet the 99% target for the fifth consecutive month with March reporting at 98.65% (76 breaches out of 5650) with the YTD also failing target at 98.84%. The Trust sole Cardiac Consultant commenced Maternity leave in November and a locum consultant recruited, however has been unable to maintain the substantive consultants workload. The Trust attempted further recruitment but this has so far been unsuccessful. All diagnostic test areas were at 100% with the exception of Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) scans which remain under target. The Trust confirmed at the Clinical Quality Review Meeting (CQRM) meeting held in April that they have seen an increased rate of referrals to the specialised CT and MRI Heart investigations due to a change in NICE guidance which has adversely impacted on overall performance. The Radiology Department continues to work closely with the Cardiac Directorate to utilise scan capacity. The Radiographers are aware of reporting issues and will flag any cases if they are deemed clinically more urgent - categories are : Inpatient (same day), Routine (within 6 weeks), Urgent (within 5 days), 62 Day Target (within 5 days) and Soon (within 2 weeks). Outsourcing of scans has been investigated, however as specialised scans require a consultant to be present during consultations this is not an option for all referrals. A mobile CT scanner is on site and routine scans are being displaced in order to create specialist capacity within the Radiology Department. The National verified figures have confirmed that breaches occurred in March for both MRI (27 breaches out of 1,211 - 97.77% ) and CT scans (49 breaches out of 685 - 92.85%) and these were the only two test areas which performed below target during the reporting period. The Trust are confident that the backlog of diagnostic tests will be cleared by the end of May 2017 and compliant by the end of June 2017. As a Commissioner, the March performance calculates at 98.62% and below target with five patients waiting longer than 6 weeks :

MRI - 1 x Nuffield Health Wolverhampton (9wks), 1 x University Hospitals of Leicester (13wks).

Urodynamics - 1 x University Hospitals of Birmingham (7wks).

Echocardiography - 1 x Oxford University Hospitals (6wks), 1 x Sandwell and West Birmingham (6 wks).

The Diagnostic waiting list continues to be discussed at the monthly CQRM and CRM meetings, as part of the CCG Assurance Call Agenda with NHS England and as part of the Quality Requirements Operational Standards contract for 2017/18 (maintaining the 99% target).

Discussion Point : Escalation of Wolverhampton patients at other Trusts.

RWT\_EB4

**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%	89.71%	91.24%	90.06%	95.00%

The Month 12 performance has failed to achieve both the National target (Type 1 and All Types) and STF Trajectory of 95%, however has seen a 1.02% increase from the previous month's performance to 91.24% (90.06% YTD). The headline performance can be split into the following: Emergency Department New Cross - 85.65%, Walk In Centre - 100%, Cannock Minor Injury Unit (MIU) - 100% and Vocare - 91.24%. When compared to the previous year's performance, there has been an increase in compliance (Mar 15/16 - 90.32%, Mar 16/17 - 91.24%). Initial comparisons of attendance numbers between 15/16 and 16/17, show an 18.03% in-month increase for March and 16.23% for the full year, however, due to multiple changes (including opening of new Emergency Department, changes to GP Referral Pathways to A&E and commencement of the Vocare Urgent Care Centre) a direct comparison is not possible. Using the Type 1 attendances as an activity baseline, data shows that there has been a -3.15% decrease in attendances (Mar16 and Mar17) but a 3.31% increase YTD. The following graph below highlights changes to systems and pathways and the attendance numbers for 15/16 (Blue), 16/17 (Red) for All Types (solid line) and Type 1 (dashed line). The Graph shows the increase in all Type attendances following the commencement of Vocare and a direct correlation between increased A&E (from Nov 15) with reduction in AMU and EAU activity figures. The Trust and CCG continue to hold Urgent Care teleconferences (Exec to Exec) three times a week and the A&E Delivery Board meetings to review progress and manage performance. A revised trajectory has been submitted and is awaiting approval from NHS Improvement (NHSI) which would provide a staggered recovery to meet national recovery trajectory of 91% by September 2017 and full compliance of the 95% target by March 2018. The March A&E performance was raised at the April Clinical Quality Review Meeting (CQRM) and the Trust confirmed issues with 1st assessments have been linked to on-going staffing issues and reliance on locum staffing. The A&E performance continues to be discussed at the monthly CQRM and CRM meetings, as part of the CCG Assurance Call Agenda with NHS England, the A&E Delivery Boards and as part of the Quality Requirements and National Operational Standards contract for 2017/18. Early indications are that the April performance (2017/18) has seen an increase to 92.5%, however, this is awaiting validation by the Trust.

RWT\_EB5



**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%	77.98%	81.18%	76.84%	85.00%

The performance for March 2017 has seen a 3.21% increase and achieved 81.18% in-month which is the highest reported performance since June 2016, however this still remains below both the Sustainability and Transformation Fund (STF) trajectory and National target of 85%. The Trust have since confirmed via the Integrated Quality and Performance Report that there were 21 patients that breached target during March (7 x tertiary referrals - all received on or after day 42 of the pathway, 6 x capacity issues, 3 x patient initiated and 5 x complex pathways). Analysis by Cancer site confirms the breaches are relating to : Urology (5 breaches out of 20.5 - 75.61%), Colorectal (3 breaches out of 8 - 62.50%), Head & Neck (2.5 breaches out of 7 - 64.29%), Upper GI (2.5 breach out of 7 - 64.29%), Gynaecology (1.5 breaches out of 5.5 - 72.73% and Haematology (3 out of 6.5 - 53.85%). Other cancer site performance reported as follows : Skin (0 breaches out of 11.5 - 100%), Lung (0 breaches out of 7 - 100%) and Breast (0 out of 20 - 100%). The Trust have confirmed that excluding tertiary referrals performance for March reports at 83.72%. Weekly escalation meetings with Divisional Managers continue to review performance with the aim to identify bottlenecks. Recruitment within the service is on-going and an experienced CT and MRI Cardiology Consultant has been recruited which should provide a positive impact on the Diagnostics performance. A revised recovery trajectory has been submitted to NHSI which includes a commitment to achieve an 80% standard throughout 17/18 however this has been rejected and discussions are on-going. Validated figures are received after the SQPR submission deadline as the final cancer figures are uploaded nationally 6 weeks after month end and March performance has been confirmed as 82.72% (16.5 patient breaching target out of 95.5) and therefore remains RED. The Month 12 performance was discussed at the March CQRM and CRM meetings with the Trust confirming that they have been in discussions with NHSI regarding the recovery trajectory. Early indications are that the April performance has seen a decrease to 77.40% and remains below target (RED).

The 62 Day Cancer waits continues to be a National issue and is to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. The performance remains as part of the Quality requirements National Operational Standards for 2017/18 with the threshold remaining at 85%.

Discussion Point : Tertiary referrals received after day 42 of the pathway (or already breached standard).

RWT\_EB12

**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%	66.67%	90.00%	85.36%	90.00%

Performance in Month 12 has seen a significant positive increase from the previous month and has achieved the 90% target in-month (90.00%) for the first time since November. The YTD however remains below target at 85.36%. The SQPR submission indicated that there was 1 breach (out of 10 patients). Analysis of the Year on Year performance shows that the M12 performance is below that of 2015/16 for the same month (15/16 - 91.30%). The Trust have confirmed that this indicator is impacted by a small cohort of 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. Weekly escalation meetings with Divisional Managers continue to review performance with the aim to identify bottlenecks. Recruitment within the service is on-going and an experienced CT and MRI Cardiology Consultant has been recruited which should provide a positive impact on the Diagnostics performance. Following the Cancer Review report (June17) the Trust have requested any further recommendations for service improvement from the Intensive Support Team (IST). Validated figures are received after the SQPR submission deadline as the final cancer figures are uploaded nationally 6 weeks after month end and March performance has been confirmed as 90.91% (1 patient breaching target out of 11) and therefore remains RED. The Month 12 performance was discussed at the March CQRM and CRM meetings with the Trust. Early indications are that the April performance has seen a positive increase to 94.74% and is therefore rated GREEN.

The 62 Day Cancer waits continues to be a National issue and is to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. The performance remains as part of the Quality requirements National Operational Standards for 2017/18 with the threshold remaining at 90%.

RWT\_EB13

### 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	24	10	422	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 March, 10 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. 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 have confirmed that the original Orthodontic long waiters back log is nearing completion with the exception of 1 complex case who has been scheduled to be seen in May. The Trust recovery trajectory is set to clear all remaining long waiters by the end of June and they are confident that this will be achieved. At the CQRM meeting held in May, the April 2017 total remaining 52 week waiters was confirmed as 7, with the expectation that May will report 5 remaining patients. Validated National Data confirms the March total as 10 waiters over 52 weeks, all Orthodontics. As a commissioner, the CCG have 1 Trauma & Orthopaedic patient waiting over 52 weeks at the Royal Orthopaedic Hospital (Birmingham). 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 52 week waiters performance remains as part of the Quality requirements Operational Standards for 2017/18 with the threshold remaining at zero per month.

### Delayed Transfers - % occupied bed days - to exclude social care delays

2.54%	3.52%	2.43%	1.29%	2.46%	2.17%	1.13%	2.13%	2.18%	1.80%	2.61%	1.68%	2.16%
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The Delayed Transfers of Care (DToc) indicator is based on the proportion of delays by occupied bed days (excluding Social Care) and has achieved the 2.5% threshold both in-month (1.68%) and Year End (2.16%). The Trust have confirmed via the Integrated Quality and Performance Report (published and available from the Trust Public website) the total performance (including social care) is 5.26%. The National verified data (based on a monthly snapshot) indicates that the Trust Delayed Transfer rankings (where 1 = worst) as 121st (out of 230 organisations) for all delay types (a total of 30 patients delayed on the snapshot survey date), 183rd for NHS responsible delays (8 patients on the snapshot) and 88th (18 patients on the snapshot) for Social Care responsible delays (plus 4 patients on the snapshot responsible to both NHS and Social Care). The issue of delays was discussed at the April CQRM meeting with Staffordshire delays continuing to have significant impact on performance. As at the March 2017 National statistics submission, there were 8 Staffordshire (Local Authority responsible) patients classified as delayed (midnight snapshot only) at the Royal Wolverhampton Hospital, which equates to 26% of the Trusts delays, the full month delay days for all Staffordshire patients was 338 (27% of the Trust delay days). The Trust have indicated the following delay reasons for March:

- 39.5% - Delay Awaiting Assessment (prev 21.6% - Increase)
- 18.4% - Delay awaiting further NHS Care (prev 22.4% - decrease)
- 21.1% - Delay awaiting domiciliary package (prev 25.0% - decrease)
- 6.4% - Delay awaiting family choice (prev 12.9% - decrease)
- 1.8% - Delay awaiting equipment/adaptations (prev 7.8% - decrease)
- 0.9% - Delay awaiting public funding (prev 5.2% - decrease)

Delayed Transfers of Care continues to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. Delays remain as part of the Local Quality Requirements Standard Contract for 2017/18 with the threshold reduced further and stretched from 2.5% to 2.0% by the end of Quarter 4. A threshold of 3.5% by September 2017 (combined NHS and Social Care related delays) has been agreed between the Royal Wolverhampton Hospital and Local Authority (stretched from 4.9% to 3.5%). A set of actions have been agreed to support this work and to achieve the threshold by September 2017.

Discussion Point : The Trust have identified the issue of Staffordshire patients as the predominant issue.

**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%	100.00%	92.31%	86.61%	95.00%

BCPFT\_LQGE05

This indicator has seen fluctuations in performance over the financial year and has failed to achieve the 95% target both in-month (92.31%) and YTD (86.61%). Performance relates to the proportion of Early Intervention Service (EIS) clients receiving an initial assessment within 10 working days and the March data refers to 13 clients in total, of which 1 client breached standard. The details of the breach have been shared with the CCG and confirms that the client cancelled initial appointments, and subsequently DNA'd (Did Not Attend) a further two appointments before being seen. The Trust have previously submitted a Remedial Action Plan (RAP), however this has yet to be agreed with the CCG. A review of the DNA policy for this service (in line with the Trusts Access Policy) has been requested by the CCG with a view to set out an action plan to help reduce the number of DNAs. The Trust have confirmed that the ability to meet this deadline is dependent on client choice and the team continue to offer 100% of referrals an appointment for assessment within the 10 day standard. This indicator is currently not part of the 2017/18 Local Quality Requirements schedule, however the 17/18 actions are to be agreed and discussed at the Clinical Quality Review Meeting (CQRM).

**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%	5.74%	5.57%	14.82%

BCPFT\_LQGE11

The Delayed Transfers of Care (DTCs) has been an on-going issue throughout the year, however the performance since January has seen a significant improvement with March reporting 5.57% against the 7.5% monthly threshold. The performance relates to the total number of delay days for the month (76) over the total number of occupied bed days excluding leave for the month (1324) 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 an increase in compliance (Mar 15/16 = 9.85%, Mar 16/17 = 5.57%). Following previous attendance requests from the Wolverhampton CCG Head of Quality & Risk, the Local Authority have attended the CQRM meeting for a dedicated discussion of actions to address the DTOC issues since January 2017. Difficulties have included the acknowledgment of differences between Social Care and Health DTOC definitions and processes, and the discussions and subsequent actions via the joint meeting has shown an immediate improvement in performance. As delayed discharges remain a National issue, performance will monitored via the 2017/18 Local Quality Requirements contract and remain an agenda item on both the CCG's monthly performance call with NHS England (NHSE) and the Trusts CQRM meetings. The graph below shows the Year End proportion of delays by delay category (category sections identified by Grey labelled columns) and responsibility (stacked columns). The graph identifies highest areas of delays YTD : NHS responsible = Housing delays (16 out of 57 delays), Social Care = Nursing Home (29 out of 97 delays).

### 3. Contract and Procurement Report

The Committee received the latest overview of contracts and procurement activities. The draft proposal setting out the CCG's expectation for MRET/readmissions/fines business cases was considered and approved.

### 4. Risks

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.

The CCG continues to have a challenging financial position for 17/18 with a number of factors outside of its direct control that could impact on its ability to deliver its financial targets. The QIPP programme for the year is substantial and the management team will continue to closely manage the delivery agenda.

## 5. RECOMMENDATIONS

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

**Name:** Lesley Sawrey  
**Job Title:** Deputy Chief Finance Officer  
**Date:** 31.5.17

**Performance Indicators 16/17**

Current Month:

**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												Yr End						
									A	M	J	J	A	S	O	N	D	J	F	M							
RWT_EB3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral*	RWT	92%	91.00%	R	90.86%	R																				
RWT_EB4	Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test*	RWT	99%	98.65%	R	98.84%	R	↑																			
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%	91.24%	R	90.06%	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%	95.83%	G	93.89%	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%	95.35%	G	95.62%	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%	96.02%	G	95.99%	R	↓																			
RWT_EB9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery*	RWT	94%	82.50%	R	83.58%	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%	98.11%	G	99.59%	G	↓																			
RWT_EB11	Percentage of Service Users waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy	RWT	94%	94.29%	G	97.38%	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%	81.18%	R	76.84%	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%	90.00%	G	85.36%	R	↑																			
RWT_EBS1	Mixed sex accommodation breach	RWT	0	0.00	G	4.00	R	↔																			
RWT_EBS2	All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice*	RWT	0	0.00	G	0.00	G	↔																			
RWT_EAS4	Zero tolerance methicillin-resistant Staphylococcus aureus*	RWT	0	0.00	G	0.00	G	↔																			
RWT_EAS5	Minimise rates of Clostridium difficile	RWT	3 (11 mths) 2 (mth 12) 35 (Yr End)	3.00	R	45.00	R	↓																			
RWT_EBS4	Zero tolerance RTT waits over 52 weeks for incomplete pathways	RWT	0	10.00	R	422.00	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	86.00	R	985.00	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	7.00	R	178.00	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	↔																			
RWT_CB_S10C	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE, as defined in Contract Technical Guidance	RWT	95%	96.49%	G	95.92%	G	↓																			
RWT_CB_S10B	Duty of candour	RWT	Yes	Yes	G	-	R	↓																			
RWT_CB_S10D	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	RWT	99.00%	99.87%	G	99.74%	G	↓																			
RWT_CB_S10E	Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	RWT	95.00%	98.90%	G	97.97%	G	↑																			
RWT_LQR1	Electronic discharge summary to be fully completed and dispatched within 24 hours of discharge for all wards excluding assessment units.	RWT	95.00%	93.28%	R	93.33%	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%	81.20%	R	82.21%	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%	1.68%	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	0.00	G	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	0.00	G	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	1.00	R	15.00	R	↑																			
RWT_LQR7	Number of cancelled operations - % of electives	RWT	0.80%	0.35%	G	0.42%	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_LQR11	Completion of electronic CHC Checklist	RWT	TBC	95.45%		91.13%	Awaiting Target	↑																			
RWT_LQR13	Maternity - Antenatal - % of women booked by 12 weeks and 6 days	RWT	90.00%	90.90%	G	90.45%	G	↑																			

RWT_LQR14	Stroke - Percentage of patients who spend at least 90% of their time on a stroke unit	RWT	80.00%	87.50%	G	89.40%	G	↓	
RWT_LQR15	Stroke - Percentage of higher risk TIA cases are assessed and treated within 24 hours	RWT	60.00%	78.26%	G	71.16%	G	↑	
RWT_LQR17	Best practice in Day Surgery - outpatient procedures - % of Day case procedures that are undertaken in an Outpatient setting	RWT	90.00%	94.00%	G	94.37%	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	2.00	R	67.00	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	23.00	G	438.00	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	8.00	G	90.00	R	↓	
RWT_LQR19a	Dressings - % formulary and exception compliance	RWT	98.00%	99.37%	G	99.44%	G		
RWT_LQR19b	Dressings - % spend via non FP10 supply route	RWT	98.00%	99.51%	G	99.49%	G		
RWT_LQR20	% Patients in receipt of TTOs within 4hours from the pharmacy receiving order	RWT	TBC	96.17%		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%	76.24%	R	92.17%	G	↓	
RWT_LQR24b	Dementia – FAIR - Percentage of patients aged 75 years and over admitted as emergency inpatients identified as potentially having dementia or delirium who are appropriately assessed.	RWT	90.00%	100.00%	G	100.00%	G	→	
BCPFT_EB3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral*	BCP	92.00%	98.31%	G	98.44%	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 specialities on CPA who were followed up within 7 days of discharge from psychiatric in-patient care*	BCP	95.00%	96.67%	G	96.64%	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%	50.00%	G	62.36%	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%	91.77%	G	92.32%	G	↓	
BCPFT_EH2	Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who are treated within 18 weeks of referral	BCP	95.00%	100.00%	G	99.60%	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	99.51%	R	→	
BCPFT_LQGE02	Percentage of EIS caseload have crisis / relapse prevention care plan	BCP	80.00%	89.36%	G	89.24%	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	47.00	G	47.00	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%	50.00%	G	62.36%	G	↓	
BCPFT_LQGE05	Percentage of all routine EIS referrals, receive initial assessment within 10 working days	BCP	95.00%	92.31%	R	86.61%	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%	83.38%	R	89.88%	G	↓	
BCPFT_LQGE07	Psychosis Medication Review - Percentage who have been prescribed and administered antipsychotic treatments for >12 months that have had an antipsychotic medications review in the previous 12 months.	BCP	85.00%	100.00%	G	100.00%	G	↑	
BCPFT_LQGE08	% compliance with local antibiotic prescribing formulary, including if there is evidence of justifiable clinical reasons for deviation from set formulary. Minimum of annual confirmation of % of compliance with the antibiotic formulary. To submit the EPACT antibiotic prescribing data to commissioners. Results to be presented to Health Protection Board. Adverse trends in unavoidable antibiotic consumption.	BCP	95.00%	100.00%	G	100.00%	G	↑	
BCPFT_LQGE09	Evidence of using HONOS: Proportion of patients with a HONOS score	BCP	95.00%	95.86%	G	95.75%	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%	5.57%	G	14.82%	R	↑	
BCPFT_LQGE12	Emergency up to 4 hours. % of assessments relating to referral within period	BCP	85.00%	95.31%	G	90.47%	G	↑	
BCPFT_LQGE13	Urgent (up to 48 hours). % of assessments relating to referral within period	BCP	85.00%	91.89%	G	86.85%	G	↑	
BCPFT_LQGE14	Routine (up to 28 days). % of assessments relating to referral within period	BCP	85.00%	91.07%	G	98.05%	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	98.81%	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	Yes	G	-	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		



**WOLVERHAMPTON CCG**  
**GOVERNING BODY**  
 11 July 2017

Agenda item 14

<b>TITLE OF REPORT:</b>	<b>Summary – Wolverhampton Clinical Commissioning Group(WCCG) Audit and Governance Committee (AGC) – 23 May 2017</b>
<b>AUTHOR(s) OF REPORT:</b>	Peter Price – Interim Chair, Audit and Governance Committee
<b>MANAGEMENT LEAD:</b>	Claire Skidmore – Chief Finance and Operating Officer
<b>PURPOSE OF REPORT:</b>	<ul style="list-style-type: none"> <li>To provide an update of the WCCG Audit and Governance Committee to the Governing Body of the WCCG.</li> </ul>
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This Report is intended for the public domain.
<b>KEY POINTS:</b>	<ul style="list-style-type: none"> <li>To provide an update of the WCCG Audit and Governance Committee to the Governing Body of the WCCG.</li> </ul>
<b>RECOMMENDATION:</b>	<ul style="list-style-type: none"> <li><b>Receive</b> this report and <b>note</b> the actions taken by the Audit and Governance Committee</li> </ul>
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	
3. System effectiveness delivered within our financial envelope	<u>Continue to meet our Statutory Duties and responsibilities</u> The Committee considered a series of items associated with the CCG's Annual Accounts and Reporting requirements, which are statutory requirements.

## **1. BACKGROUND AND CURRENT SITUATION**

- 1.1 2016/17 – Chief Internal Auditor Progress Report/Stakeholder Engagement/Conflicts of Interest/Information Governance Toolkit  
The Committee considered the Chief Internal Auditor Progress Report and final audit reports for Stakeholder Engagement; Conflicts of Interest and Information Governance Toolkit. These were accepted by the committee.
- 1.2 2016/17 Report to those charged with Governance (ISA260)  
The External Audit team reported their findings for the year 2016/17 and advised that they anticipated that they would be in a position to issue an unqualified audit opinion on the financial statements.
- 1.3 Management Representation Letter  
The Management Representation Letter was presented by the Head of Financial Resources.
- 1.4 CCG Annual Report, Accounts and Governance Statement  
The Annual Report, Accounts and Governance Statement were presented to the Audit and Governance Committee and the committee gave their recommendation for the Governing Body to sign them off.
- 1.5 2017/18 Internal Audit Plan  
The Committee were presented with a report outlining proposed activities for 2017/18. The committee agreed the work plan for the year.

## **2. CLINICAL VIEW**

- 2.1. N/A

## **3. PATIENT AND PUBLIC VIEW**

- 3.1. N/A

## **4. KEY RISKS AND MITIGATIONS**

- 4.1. The Audit and Governance Committee will regularly scrutinise the risk register and Board Assurance Framework of the CCG to gain assurance that processes for the recording and management of risk are robust. If risk is not scrutinised at all levels of the organisation, particularly at Governing Body level, the CCG could suffer a loss of control with potentially significant results.

## **5. IMPACT ASSESSMENT**

### ***Financial and Resource Implications***

Governing Body Meeting  
11 July 2017

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5.1. N/A

***Quality and Safety Implications***

5.2. N/A

***Equality Implications***

5.3. N/A

***Legal and Policy Implications***

5.4. N/A

***Other Implications***

5.5. N/A

**Name: Claire Skidmore**

**Job Title: Chief Finance and Operating Officer**

**Date: 24 May 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.**

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



**WOLVERHAMPTON CCG**
**GOVERNING BODY MEETING**  
**11 JULY 2017**
**Agenda item 15**

<b>TITLE OF REPORT:</b>	Summary – Primary Care Commissioning Committee – 2 May 2017 and 6 June 2017
<b>AUTHOR(s) OF REPORT:</b>	Pat Roberts, Primary Care Commissioning Committee Chair
<b>MANAGEMENT LEAD:</b>	Mike Hastings, Associate Director of Operations
<b>PURPOSE OF REPORT:</b>	To provide the Governing Body with an update from the meetings of the Primary Care Commissioning Committee on 2 May 2017 and 6 June 2017.
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This Report is intended for the public domain.
<b>KEY POINTS:</b>	<ul style="list-style-type: none"> <li>• The Zero Tolerance Policy commenced as of 1 April 2017 and there are currently 12 patients on the scheme.</li> <li>• An application and business case to close Dunkley Street Surgery was approved.</li> </ul>
<b>RECOMMENDATION:</b>	The Governing Body is asked to note the progress made by the Primary Care Joint Commissioning Committee.
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	
1. Improving the quality and safety of the services we commission	The Primary Care Commissioning Committee monitors the quality and safety of General Practice.
2. Reducing Health Inequalities in Wolverhampton	The Primary Care Commissioning Committee works with clinical groups within Primary Care to transform delivery.
3. System effectiveness delivered within our	Primary Care issues are managed to enable Primary Care Strategy delivery.

financial envelope	
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## 1. BACKGROUND AND CURRENT SITUATION

1.1. The Primary Care Commissioning Committee met on 2 May 2017 and 6 June 2017. This report provides a summary of the issues discussed and the decisions made at those meetings.

## 2. PRIMARY CARE UPDATES

### Primary Care Commissioning Committee – 2 May 2017

#### 2.1 Extended Opening Hours Schemes Joint Evaluation Report

2.1.1 The Improving Access in Primary Care 2016/17 report was presented to the Committee which provided an overview of the three CCG extended access schemes which took place between December 2016 – March 2017.

2.1.2 The three schemes were as follows:

- A&E Delivery Board (CCG) Christmas and New Year funded opening scheme.
- NHS England Winter Pressures.
- CCG Extended Winter Pressures offering additional appointments from 4 March – 31 March 2017.

2.1.3 An overview in terms of finance and performance for each scheme was provided and a variation in respect of patient attendance was noted. The following points were highlighted;

- Varied performance for Christmas and New Year CCG Scheme, 91% utilisation on 5 dates made available to patients which would not normally be available, this included Christmas Eve and New Year's Eve.
- 94% total attendance rate of patients overall during Winter Pressures NHS England Scheme.
- Extended Winter Pressures - CCG Scheme (64% attendance rate of patients attending extra slots on Saturdays and 75% weekdays).

2.2 The Committee received the following update reports:-

#### 2.2.1 Primary Care Operational Management Group Meeting

The Committee noted that the Primary Care Contract Monitoring visits continue and a schedule for the next 6 months have been arranged. It was also stated that the Zero Tolerance Policy commenced as of 1 April 2017 and that there are currently 12 patients on the scheme.

## 2.3 Other Issues Considered

- 2.3.1 The Committee met in private session to discuss a change in partnership at Ashmore Park Medical Centre and Black Country Healthcare Estates

### **Primary Care Commissioning Committee – 6 June 2017**

## 2.4 Application to close a branch site at Dunkley Street

- 2.4.1 An application and business case to close Dunkley Street Surgery, which is a branch of Prestbury Medical Practice, was presented to the Committee. The patient engagement process that had been undertaken was outlined. The results were considered by the Committee and the business case was approved with the proviso that the patients are fully supported through the process with information and registration if required.

- 2.5 The Committee received the following update reports:

### 2.5.1 Primary Care Strategy Committee

An overview of the Primary Care Strategy programme milestones that have been achieved since the summer of 2016, particular focus was given around the priorities of the Task and Finish Groups.

The Committee noted that the General Practice 5 Year Forward View CCG Plan has been fully assured by NHS England and the programmes of work are underway to implement each of the projects.

### 2.5.2 Primary Care Operational Management Group

The Committee noted that the Quality Team are undertaking a review of the Information Governance breaches which have been raised through Quality Matters. Assurance has been given that they have reduced due to awareness being increased and training being delivered.

It was also stated that the estates prioritisation exercise is in the process of being finalised and will be shared with the Governing Body in due course.

## 2.7 Other Issues Considered

2.7.1 The Committee met in a private session to discuss the procurement of a caretaker provider for Ettingshall Medical Centre and the Primary Care Committee risk register.





### **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:** 27 June 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.**

	<b>Details/ Name</b>	<b>Date</b>
Clinical View	<b>N/A</b>	
Public/ Patient View	<b>N/A</b>	
Finance Implications discussed with Finance Team	<b>N/A</b>	
Quality Implications discussed with Quality and Risk Team	<b>N/A</b>	
Equality Implications discussed with CSU Equality and Inclusion Service	<b>N/A</b>	
Information Governance implications discussed with IG Support Officer	<b>N/A</b>	
Legal/ Policy implications discussed with Corporate Operations Manager	<b>N/A</b>	
Other Implications (Medicines management, estates, HR, IM&T etc.)	<b>N/A</b>	
Any relevant data requirements discussed with CSU Business Intelligence	<b>N/A</b>	
<b>Signed off by Report Owner (Must be completed)</b>	<b>Pat Roberts</b>	<b>27/06/17</b>

**WOLVERHAMPTON CCG**  
**Governing Body**  
**11 July 2017**

**Agenda item 16**

<b>TITLE OF REPORT:</b>	Report of the Primary Care Strategy Committee
<b>AUTHOR(s) OF REPORT:</b>	Sarah Southall, Head of Primary Care
<b>MANAGEMENT LEAD:</b>	Sarah Southall, Head of Primary Care
<b>PURPOSE OF REPORT:</b>	To update the governing body on continued progress that has been demonstrated to the Primary Care Strategy Committee following it's last meeting held on 15 June 2017.
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This Report is intended for the public domain.
<b>KEY POINTS:</b>	<ul style="list-style-type: none"> <li>• Provide assurance on the outcome of a series of deep dives that had taken place involving each Task &amp; Finish Group, including revised terms of reference for consideration.</li> <li>• The outcome of discussions regarding Bank Holiday Opening is also reflected in the report.</li> <li>• The Primary Care Strategy Implementation Plan is currently under review, the committee's objectives have been updated.</li> <li>• Progress made towards ongoing implementation of the General Practice Five Year Forward View Programme of Work is also provided within the report.</li> </ul>
<b>RECOMMENDATION:</b>	<p>The recommendations made to governing body regarding the content of this report are as follows:-</p> <ul style="list-style-type: none"> <li>• Receive and discuss this report</li> <li>• Note the assurance provided by the Committee</li> </ul>
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	<ol style="list-style-type: none"> <li>1 Improving the quality and safety of the services we commission : Ensure on-going safety and performance in the system</li> <li>2 Reducing Health Inequalities in Wolverhampton : Improve and develop primary care in Wolverhampton; Deliver new models of care that support care closer to home and improve management of Long Term Conditions.</li> <li>3 System effectiveness delivered within our financial envelope : Deliver improvements in the infrastructure for health and care across Wolverhampton</li> </ol>



## 1 BACKGROUND AND CURRENT SITUATION

- 1.1. The CCGs Primary Care Strategy Implementation commenced in the summer of 2016. The corresponding programme of work has recently been revisited to determine progress and the effectiveness of action taken to date. This report confirms the findings from the review & paves the way for a series of changes that will be made to the programme of work to ensure the content is reflexive & aligned with other influencing factors that may have an impact on successful implementation.
- 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 Deep Dive Evaluation Report

Following a series of deep dive reviews that had taken place during May with each of the Task and Finish Group Leads the committee considered the findings from those reviews. There were 4 key themes were as follows:-

- Four of the seven Task and Finish Groups programmes of work had been halted pending reviews of the Terms of Reference. They are identified as:
  - Practice as Providers
  - Localities as Commissioners
  - Workforce and Development
  - Primary Care Contract Management

Revised Terms of Reference have since been considered by the committee and their respective programmes of work are currently being adjusted to reflect changes. Copies of each of the above are attached for consideration.

- Three of the seven Task and Finish Groups programmes of work will be dependent on the future outcomes pertaining to possible MCP contracting models for place based commissioning. They were noted as follows:-
  - Practice as Providers
  - Primary Care Contract Management
  - Clinical Pharmacists
- Identified there is a need for New Models of Care to work in a more collaborative way to avoid replication.
- An options appraisal will be brought back to the next Primary Care Strategy Meeting and moving forward there would be quarterly updates on Patient Online to the meeting.

The revised programmes of work will be considered in more detail when the committee meets again on 20 July 2017.

## **2.2 Bank Holiday Opening Report**

A report was considered based on bank holiday opening that had been introduced for each bank holiday arising during 2017/18 financial year. Funds had been secured via the Accident & Emergency Delivery Board to enable General Practice Hubs to open across the city. The intention was to reduce the burden on the urgent care system, reduce demand & 'catch up' for general practice when practices reopened following bank holiday periods, whilst affording patients the opportunity to see a GP at the nearest hub.

The report confirmed attendance levels over Easter and early May Bank Holiday had been lower than expected. However, activity over late May Bank Holiday had improved across all 4 hubs that were open.

Patients had provided very positive feedback regarding the availability of the service & the committee agreed that the cost effectiveness and any reduction in attendances at the city's Urgent Care Centre should be considered in future reports.

## **2.3 Primary Care Strategy Implementation Progress**

In June the Governing Body were able to reflect on evidence of a series of achievements that been had made by the Primary Care Strategy Committee. Whilst the programme of work is now under review, it is the intention to share with the governing body in September a copy of the milestone plan for the coming year. The milestone plan will define activities that continue to afford assurance of delivery and where necessary delays in achievement. The milestone plan will span all areas of the programme of work.

## **2.4 General Practice Forward View**

The committee considered the extent of progress made regarding a range of projects that were now established. More than 50% of projects are now up & running comprising of:-

- A range of training programmes for primary care personnel ie Practice Manager, Aspiring Practice Manager, Time for Care, Nurse Mentorship, Apprenticeships, Care Navigation etc
- Recruitment & retention to a variety of roles include clinical pharmacists, social prescribers,
- Focus on new models of care & the developing general practice team
- Transformation work attached to the 10 High Impact Actions including working at scale and improving access

The programme of work will continue to be overseen by the committee will develop further over the coming months in response for further guidance from NHS England and ongoing collaborative working with other CCGs within our STP area.

### 3 CLINICAL VIEW

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

### 4 PATIENT AND PUBLIC VIEW

- 4.1 Whilst patients and the public were engaged in the development of the strategy and a commissioning intentions event held in the summer specific to primary care the Governing Body should note that Practice based Patient Participation Groups are being encouraged to ensure their work with the practice(s) encompasses new models of care and the importance of patient and public engagement moving forward.
- 4.2 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.

### 5 RISKS AND IMPLICATIONS

#### ***Key Risks***

- 7.1 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***

- 7.2 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***

- 7.3 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***

- 7.4 The Strategy has a full equality analysis in place. This will require periodic review during the implementation phase.

#### ***Medicines Management Implications***

- 7.5 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***

- 7.6 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.

Enclosure(s) Terms of Reference Practices as Providers  
Terms of Reference Primary Care as Commissioners  
Terms of Reference Workforce  
Terms of Reference Primary Care Contracting

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

**SLS/GBR-PCSC/JUL17/V2 FINAL**



### 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.**

	<b>Details/ Name</b>	<b>Date</b>
Clinical View	<b>Salma Reehana</b>	<b>3.7.17</b>
Public/ Patient View	<b>Pat Roberts</b>	<b>3.7.17</b>
Finance Implications discussed with Finance Team	<b>NA</b>	
Quality Implications discussed with Quality and Risk Team	<b>NA</b>	
Equality Implications discussed with CSU Equality and Inclusion Service	<b>NA</b>	
Information Governance implications discussed with IG Support Officer	<b>NA</b>	
Legal/ Policy implications discussed with Corporate Operations Manager	<b>NA</b>	
Other Implications (Medicines management, estates, HR, IM&T etc.)	<b>NA</b>	
Any relevant data requirements discussed with CSU Business Intelligence	<b>NA</b>	
<b>Signed off by Report Owner (Must be completed)</b>	<b>Steven Marshall</b>	<b>3.7.17</b>





# Wolverhampton CCG General Practice as Commissioners - Task and Finish Group

## Terms of Reference

### 1. Introduction

The General Practices as Commissioners Task and Finish Group has the responsibility to ensure the Localities/GP Groupings have the essential arrangements in place to deliver their functions effectively. The key areas to address include developing plans to address the following:

- Governance/Functions of Locality Meetings
- Commissioning and Contracting Cycle
- Commissioning within a predefined financial envelope that meets the needs of the Locality registered list.
- Monitoring and Quality
- Engagement and Development of Services
- Business Intelligence and Data

The Task and Finish Group need to ensure information sharing and appropriate links with other Task and Finish Groups and the Better Care Wolverhampton Programme to ensure these interdependencies are aligned and working collaboratively to reduce the risk of duplication.

Its role is to achieve the transition from present way of working to the one set out by Strategy and then to ensure the new way of working becomes business as usual. Once this has been achieved the Task and Finish Group will be disbanded, unless there are on-going activities which exist beyond the transformation delivery duration.

Task and Finish Group Structure:



## 2. Membership

Core membership will comprise of the following personnel:-

- Primary Care Transformation Manager (Chair)
- Nominated Locality Chair Representative
- Head of Strategy & Transformation
- Finance Representative
- IM&T/ Business Intelligence
- Primary Care Home (Wolverhampton Total Health Care nominated Representative)
- Operations Representative

There may be occasions when other representatives are co-opted or invited to attend these meetings.

## 3. Meeting administration

- 3.1 The Chair, with the support of their Admin support, will be responsible for ensuring circulation of the agenda and papers of the Task & Finish Group at least three working days before the meeting.
- 3.2 Circulation of the minutes/action notes will be completed by the chair/admin support within five working days of the meeting to all members.
- 3.3 The action log will be maintained, monitored and chased by the Business and Performance Primary Care PMO Administrator and they will send reminders to all the T&F Group members prompting updates at least three working days before the meeting.
- 3.4 Following the meetings, the Chair will provide a highlight report based on key discussion points/ actions, to the Business and Performance Primary Care PMO Administrator within 3 working days, for presentation at the next Primary Care Strategy Committee.

## 4. Quorum

- 4.1 The group will be quorate if the chair along with the nominated locality chair representative and a CCG lead are present.
- 4.2 In the event of other members being unable to attend meetings they must ensure a nominated deputy is identified to aid continuity of the program and discussions at the meeting.

## 5. Voting

- 5.1 The Task & Finish Group is expected to take most decisions by consensus. Where a decision cannot be reached, this will be escalated to the Primary Care Strategy Committee.

## 6. Frequency

- 6.1 Meetings will be held at monthly intervals.

## 7. Remit, duties and responsibilities:

- 7.1 The remit of this Task and Finish Group is to ensure all member practices are fully involved, particularly at locality level, and are engaged in developing the operating function of the Locality meetings and networks covering North East, South East and South West to be more commissioner led.

Pivotal to this is to strengthen collaborative working across the Localities and Clinical Networks in par with the CCG mission:

*We will be an expert clinical commissioning organisation, working collaboratively with our patients, practices and partners across health and social care to ensure evidence-based, equitable, high quality and sustainable services for all of our population.*

- 7.2 The three ways Member Practices are involved in the commissioning undertaken by the CCG on their behalf is:
- By participation the quarterly membership meetings
  - By participation through localities
  - By participation in focussed work to review present services and develop new services
- 7.3 Oversight and development of Localities as commissioners ensuring that the localities have appropriate arrangements in place to exercise their; functions effectively, efficiently and economically and in accordance with the localities terms of reference and governance.

This will include 5 key areas, detailed below:

#### **Governance/Functions of Locality groups/ clinical network groups**

- Ensuring structures, systems and processes are in place for locality groups to be involved in the decision making processes of the CCG.
  - Discussions held at Locality/ clinical network groups need to be recognised when recommendations and decisions are made at Programme Boards and Commissioning committees
  - Work to ensure that engagement at practice and locality level is maximised to ensure discussions at this level are truly reflective of the views of practitioners and teams delivering services.

#### **Commissioning and Contracting Cycle**

- Develop a yearly planning template to incorporate the localities and clinical network priorities for the year 2017/18 and beyond.
- Developing processes for commissioning-Extended Primary Care services schemes which will seek to increase the range of services delivered out of hospital, where indicated by local evidence
- Using relevant Contract clauses to full effect to increase the quality and cost effectiveness of all CCG held contracts and thus reduce risk
- Oversight of the application of the agreed pricing model for Primary Care Services
- To ensure that practice indicative budget statements are developed and rolled out. Work with practice teams to ensure that the statements are considered in local decision making.
- Encourage practices/ networks to identify any QIPP opportunities and develop these and include within clinical network delivery plans.

#### **Monitoring and Quality**

- Developing processes to ensure locality/ clinical networks monitor activity and spend against plan by contract through scrutiny of practice level or locality/ clinical network reports and consider responses and remedial actions where indicated.
- Embed the GP Peer Review Scheme across clinical networks to improve quality, cost and reduce variation in referral patterns across a range of clinical specialties where there is a high number of referrals from primary to secondary care.  
To enable this to take place, scrutiny of referral behaviours will be carried out by impartial experts e.g. GPs with special interests from outside of the CCG where applicable.
- Ensuring processes are in place to identifying service redesign/clinical pathway review opportunities to increase the range of out of hospital extended services.

## **Engagement and Development of services**

- Ensure localities are involved in the development of commissioning intentions, CQUINS, QIPP projects and the overall service strategy of the CCG for all providers and agencies.
- Ensure localities are involved in the review and development of existing and new pathways and services.
- Clearly defined processes to enable Practices to feed back their and their patient's experience of using commissioned services.

## **Business Intelligence and Data**

- Ensure there is a comprehensive range of reports/reporting formats for all data to be used at locality, clinical network and practice level. This includes:
  - Practice group level budget statements
  - Practice group level data dashboards utilising data held within the Primary Care Web-tool, Aristotle business intelligence, Public Health Observatory
- The development of locality dash boards and actively supporting the implementation of QIPP Plans, Quality Premium spending plans, Annual Operating Plan etc. as required by NHSE.
- Practice level intelligence should be collated and reviewed to determine clinical need and patient outcomes.

## **8. Reporting**

- 8.1 The Task & Finish Group will report to the Primary Care Strategy Committee (frequency to be confirmed).

## **9. Review of Terms of Reference**

- 9.1 These terms of reference will be reviewed by the T&F group and Primary Care Strategy Committee annually to ensure the group is achieving its objectives and to ensure that key changes are being incorporated as required.

# Wolverhampton CCG Practices as Providers Task and Finish Group updated 12 06 2017

## Terms of Reference

### 1. Introduction

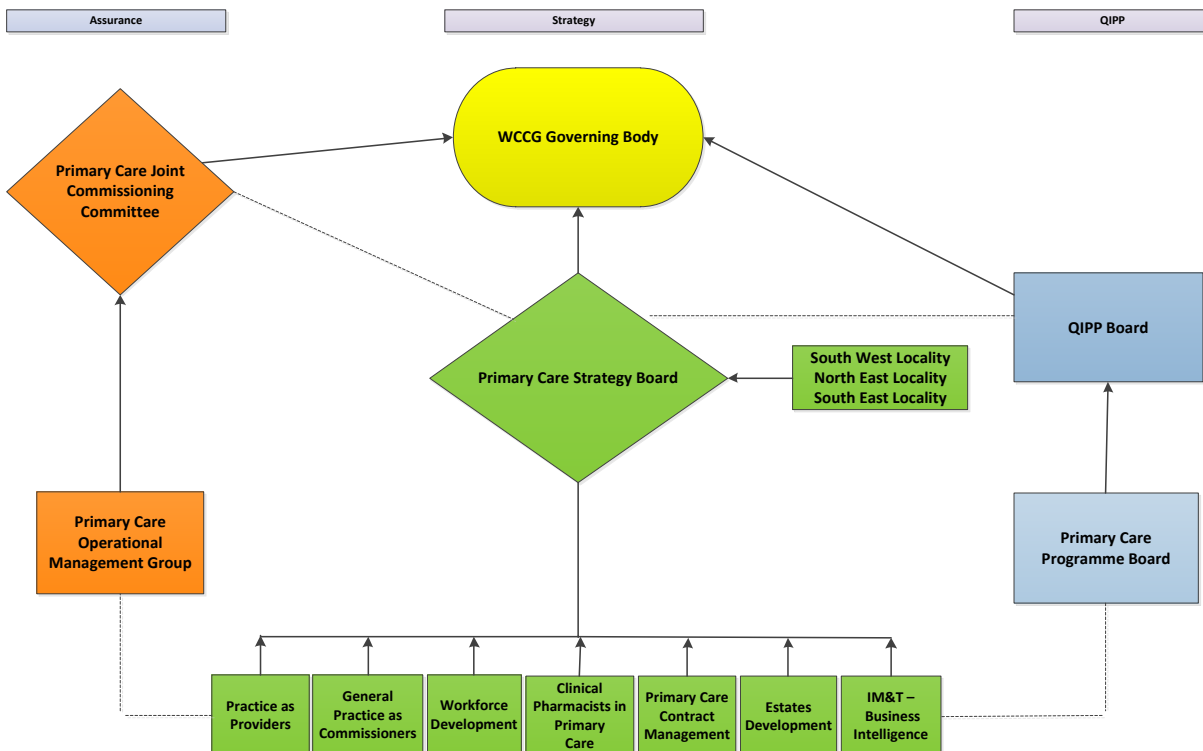
The aim of Practices as Providers Task and Finish Group is to develop GP Clinical Networks in line with GPs to encourage working relationships to strengthen boundaries across Primary and Community Care services in order to develop a Primary Care Model of Care. This is one of the key work streams within the Primary Care Strategy to ensure the Wolverhampton have a Primary Care Model that is resilient to future changes. The Task and Finish Groups role is to define and develop an understanding of infrastructure requirements to support the practices delivery including back office functions in order to support the approach of implementing the Primary Care Model of Care.

It has the responsibility to establish working relationships with practices to devise an approach of bringing practices together to support the movement of specialist care out of hospitals into the community, which is in line with the National Multi-specialty Community Provider (MCP) models of care.

The Task and Finish Group need to ensure information sharing and appropriate links with other Task and Finish Groups and the Better Care Wolverhampton Programme to ensure these interdependencies are aligned and working collaboratively to reduce the risk of duplication.

Its role is to achieve the transition from present way of working to the one set out by Strategy and then to ensure the new way of working becomes business as usual. Once this has been achieved the Task and Finish Group will be disbanded, unless there are on-going activities which exist beyond the transformation delivery duration.

### Task and Finish Group Structure



## **2. Membership**

Core membership will comprise of the following personnel:-

Primary Care Transformation Manager (Chair)

GP Locality Leads

New models of care representative

Head of Integrated Commissioning

LMC Representative

Solutions and Development Manager -Community Services

There may be occasions when other representatives are co-opted or invited to attend these meetings.

## **3. Meeting administration**

- 3.1 The Chair, with the support of their Admin support, will be responsible for ensuring circulation of the agenda and papers of the Task & Finish Group at least three working days before the meeting.
- 3.2 Circulation of the minutes/action notes will be completed by the chair/admin support within five working days of the meeting to all members.
- 3.3 The action log will be maintained, monitored and chased by the Business and Performance Primary Care PMO Administrator and they will send reminders to all the T&F Group members prompting updates at least three working days before the meeting.
- 3.4 Following the meetings, the Chair will provide a highlight report based on key discussion points/ actions, to the Business and Performance Primary Care PMO Administrator within 3 working days, for presentation at the next Primary Care Strategy Committee.

## **4. Quoracy**

- 4.1 Meetings of the group will be quorate if the chair and 2 other members are present. In the event of members being unable to attend meetings they must ensure they identify a nominated deputy to aid continuity of the program and discussions at the meeting. Where it is possible, the group will also conduct business 'virtually' to ensure that all members have the opportunity to comment on proposals.

## **5. Voting**

- 5.1 The Task & Finish Group is expected to operate by consensus wherever possible. In circumstance where a decision cannot be reached, the chair will escalate the issue to the Primary Care Strategy Committee.

## **6. Frequency**

Meetings will be held at monthly intervals.

## **7. Remit, duties and responsibilities**

- 7.1 In light of the General Practice 5 Year Forward View the vision is to work with Localities/Clinical Networks to explore and test general practice models, which are fit for the future and demonstrate sufficient resilience to future challenges inclusive of:-

**Practices collaborating to improve access**

- Shared access to records
- Seven day services
- Practices coming together collaboratively to deliver out of hospital services
- Overseeing the implementation of initiatives aligned with the 10 High Impact Actions to release time to care:
  - 1 Active signposting
  - 2 New consultation types
  - 3 Develop the team
  - 4 Reduce DNAs
  - 5 Productive Workflows
  - 6 Personal Productivity
  - 7 Partnership Working
  - 8 Use Social Prescribing
  - 9 Self Care
  - 10 Build QI Expertise
- Practices undertaking GP Peer Review and referral management to reduce unwarranted variation

**Integrating primary and community services**

Development of Integrated Primary Care Model of care, place and population based approach, geographically coherent across localities, consisting of the following characteristics;

- Best Practice models
- MCP approach in line with national MCP framework
- Wider primary care team, with wrapped around community teams across Locality Hubs incorporating both health and social care provision as aligned with the Better Care Wolverhampton programme
- Risk Stratification and admissions avoidance for high risk individuals

**Sharing of Back Office functions** to enable practices working at scale including:

- Legal Advice
- Payroll
- Interpreting Services
- Supplies and Ordering
- Human Resource support
- IT, information sharing and clinical templates
- Standard set of policies and procedures
- Business intelligence and Data
- Medicine Optimisation and Prescribing Support
- Contract Management

**8. Reporting**

- 8.1 The Task & Finish Group will report to the Primary Care Strategy Committee on a monthly basis. The Primary Care Strategy Committee will oversee the programme of work for this, and all other Task and Finish Groups.
- 8.2 Workstream leads will need to ensure they alert each other if implications for another workstream are identified (which will be reflected in the highlight report).

**9. Review of Terms of Reference**

- 9.1 These terms of reference will be reviewed by the T&F group and Primary Care Strategy Committee annually to ensure the group is achieving its objectives and to ensure that key changes are being incorporated as required.

**10. TOR agreed at:**



**Wolverhampton CCG**  
**Primary Care Contract Management - Task and Finish Group**

**Terms of Reference**

**1. Introduction**

The Task and Finish Group has been up and running for approximately 12 months. On 12<sup>th</sup> May 2017, a deep dive meeting took place to review progress of the group. The summary points from this are as follows:

Two out of three key deliverables have been achieved. These are;

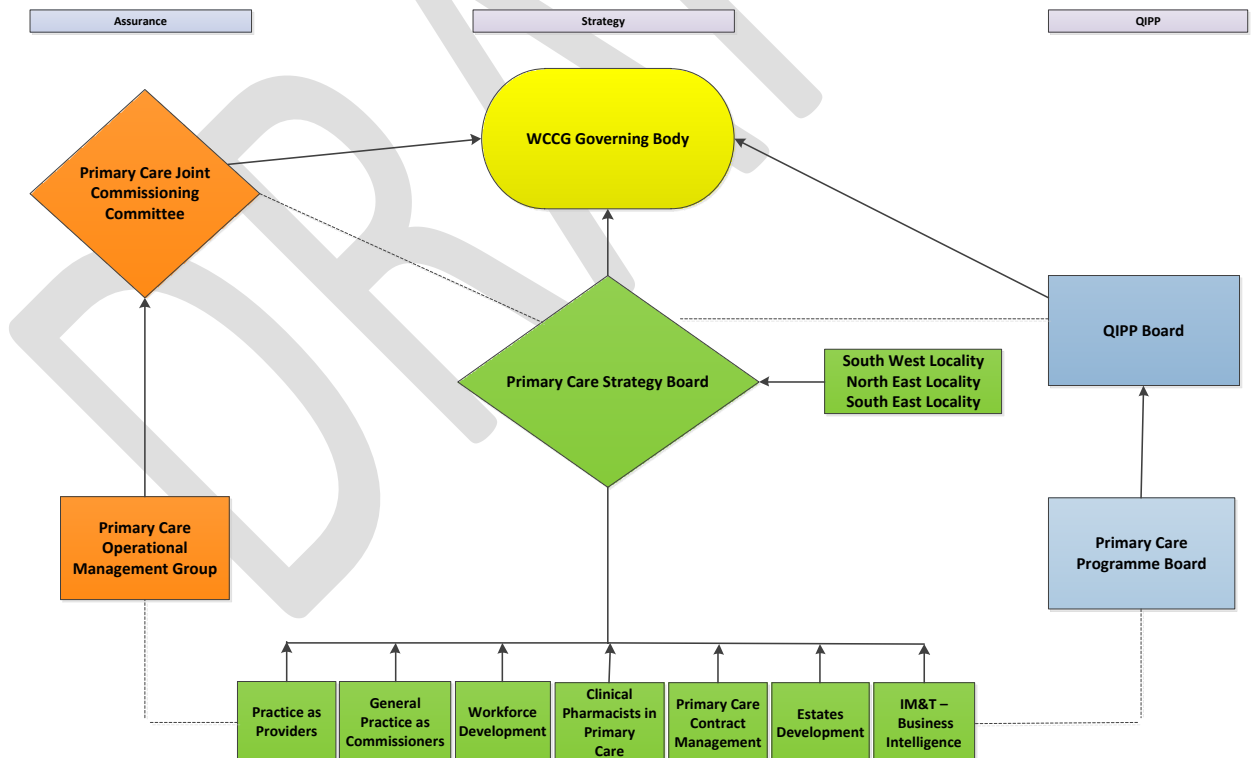
- *Collaborative Working between NHSE, CCG and Public Health*
- *Progression to Fully Delegated Commissioning*

The third area of delivery for the group is the development of the New Models of Care. The Task and Finish Group will be one of the key mechanisms to support implementation and delivery of virtual Alliance Incentive-based Contract spanning secondary and primary care.

It was agreed this needed to become the main focus for the next 12 months and the Terms of Reference and programme of work need to be amended accordingly.

This version of the terms of reference aims to reflect the revisions referenced above.

Task and Finish Group Structure:



## 2. Membership

Head of Contracting and Procurement (Chair)  
Head of Primary Care  
Primary Care Contracts Manager  
GP Representative(s)  
Local Authority Representative (Commissioning Manager for Public Health)  
Finance Representative (specific rep to be confirmed)

\*This was a recommendation from the Deep Dive meeting given the focus on the Virtual MCP contract and the need to ensure appropriate links between contracting and finance.

Other people will be co-opted as required, for example the CCG's Corporate Operations Manager for advice on Governance issues, the Director of Strategy and Transformation for advice on strategic direction and the Equality and Diversity Lead.

## 3. Meeting administration

- 3.1 The Chair, with the support of their Admin support, will be responsible for ensuring circulation of the agenda and papers of the Task & Finish Group at least three working days before the meeting.
- 3.2 Circulation of the minutes/ action notes will be completed by the chair/ admin support within five working days of the meeting to all members.
- 3.3 The action log will be maintained, monitored and chased by the Business and Performance Primary Care PMO Administrator and they will send reminders to all the T&F Group members prompting updates at least three working days before the meeting.
- 3.4 Following the meetings, the Chair will provide a highlight report based on key discussion points/ actions, to the Business and Performance Primary Care PMO Administrator within 3 working days, for presentation at the next Primary Care Strategy Committee.

## 4. Quoracy

- 4.1 There should be a minimum of 4 people in attendance (including the chair) for the meeting to be quorate. A representative from each organisation should be present as far as possible. Members should nominate a deputy to attend in their absence.

## 5. Frequency of meetings

- 5.1 The meetings will be held monthly

## 6. Remit, duties and responsibilities

- 6.1 Key objective - oversight and development of a New Model of Care (in line with the Five Year Forward View) with the aim of achieving effective contract management to ensure high quality of service provision.

- 6.2 Context

- There is a strong push from NHSE to establish a MCP/ PACS approach and find a workable local solution
- The solution must not lead to de-stabilisation of local providers, in particular RWT
- There is a strong consensus amongst local GPs to retain their GMS contracts and the majority of GPs do not wish to vertically integrate
- There is a lack of clarity over community services commissioned from RWT
- A joint executive meeting between the CCG and RWT took place in May, at which future contracting models formed the basis of the agenda. There was agreement reached in principle to put in place a virtual alliance contract.

#### **6.1.1 Implementation of a Virtual Alliance Contract**

- Ensure collaborative working approach across the Health Economy
- Review and appraise national guidance on MCP/ PACS contracting models
- Learn from other areas who have implemented change in this area, for example Bolton CCG implemented a radically different outcomes based contract with their local acute trust which moved them away from PbR.
- Agree scope of services to be included in the virtual contract
- Agree different incentive categories ie activity reduction, cost reduction, risk/ gain share, fixed income and which service groups should be allocated to each.
- Clearly identify the contracting mechanisms to be used.
- Identify risks on an ongoing basis
- Implement virtual contract by 1 April 2018.

#### **6.1.2 Development of New Models of Care.**

- Recognise new and emerging models of care (eg VI/ PCH) and the need for appropriate contracting approaches for these.
- Ensure clearly defined contract review arrangements are consistent with the CCG's wider contract review programme (collaborative model)

### **7. Reporting**

- 7.1 The Task & Finish Group will report to the Primary Care Strategy Committee. Documentation to be completed and presented to the Committee includes monthly progress assurance updates via the workbooks, implementation chart and control documents/ exception reports.
- 7.2 Workstream leads will need to ensure they alert each other if implications for another workstream are identified (which will be reflected in the highlight report).

### **8. Review of Terms of Reference**

- 8.1 These terms of reference will be reviewed by the T&F group and Primary Care Strategy Committee annually to ensure the group is achieving its objectives and to ensure that key changes are being incorporated as required.

### **9. TOR agreed at:**

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## Wolverhampton CCG Workforce Development - Task and Finish Group

### Terms of Reference

#### 1. Introduction

The aim of the Workforce and Development Task and Finish Group is to deliver the vision of the Primary Care Workforce Strategy. The purpose of the group is to ensure the strategy is reflective of national and local influencing factors and is duly implemented to assist in achieving a sustainable workforce for Primary Care in Wolverhampton.

Through implementation of the strategy, gaps in clinical / non clinical roles will be redefined and strengthened, training and development needs will be proactively managed and recruitment and retention of a range of new roles advocated in the General Practice Five Year Forward View will also be introduced at practice level.

This is one of the key work streams within the Primary Care Strategy to ensure Wolverhampton CCG have a comprehensive plan in place to retain, strengthen and develop a sustainable Primary Care Workforce for the future.

Its role is to achieve the transition from the present way of working to the one set out by the strategy and to ensure the new way of working becomes an approach that is pro-actively business as usual.

The achievements of the Task and Finish Group will be reviewed periodically to ensure progression is taking place and to determine the future of the group.

Task and Finish Group Structure:



#### 2. Membership

**Core -**  
(Chair)

Primary Care Clinical lead (Vice Chair)

Primary Care Development Manager

GP Lead (Locality Lead)

### **Attendance on-request -**

Health Education West Midlands - Primary Care Workforce Lead

Local Education Training Board – Primary Care forum reps

Vocational Training Scheme(s) - Programme Director

Representative from:

- Clinical pharmacist
- Appraisal lead
- Clinical Education for Practice Nurses
- Primary Transformation Manager/Head of Service
- University of Wolverhampton
- Social care
- Third sector
- Acute
- MH Provider
- New Models of Care / Localities
- LMC

### **3. Meeting Administration**

- 3.1 The Chair, with support of their administrative support, will be responsible for ensuring circulation of the agenda and papers of the Task and Finish Group at least three working days before the meeting.
- 3.2 Circulation of the minutes/action notes will be completed by the chair/admin support within five working days of the meeting to all members.
- 3.3 The action log will be maintained, monitored and chased by the Business and Performance Primary Care PMO Administrator and they will send reminders to all the TandF Group members prompting updates at least three working days before the meeting.
- 3.4 Following each meeting, the Chair will ensure the respective workbook for the programme of work is duly updated for assurance to the responsible committee. The workbook will be provided directly to the Business and Performance Primary Care PMO Administrator within 3 working days, for presentation at the next Primary Care Strategy Committee.

### **4. Quorum**

- 4.1 Two of the following must be present from the core membership to enable meetings to take place:-

xx (Chair)  
Primary Care Clinical Lead  
Primary Care Team Representative  
GP Lead (Locality Lead)

Decision making will be ratified by Primary Care Strategy Programme Board.

### **5. Voting**

- 5.1 The Task and Finish Group is expected to take most decisions by consensus, where a decision cannot be reached this will be escalated to the responsible committee.

### **6. Frequency of Meetings**

- 6.1 Monthly

### **7. Remit, duties and responsibilities**

- 7.1 The overarching role of this group will be to:
  - In view of the changing landscape, review and update the Primary Care Workforce Strategy covering all staff groups spanning both clinical and non-clinical roles within Primary Care. All in accordance with the CCGs Primary Care Strategy (2016) and General Practice Five Year Forward View (2016).
  - Review and update the current implementation plan and continue to deliver the aims of the Strategy through the Plan.
  - Assume responsibility for implementation of the strategy at practice group/locality level whilst striving to achieve a more resilient workforce for the future.
  - Identify any risks likely to have an impact on the delivery of the strategy and ensure early mitigation plans are in place and reported to the responsible committee in a timely manner.
  - Ensure that the programme of work for the task and finish group is reflective of all corresponding expectations for the primary care workforce as advocated in the General Practice Five Year Forward View and Primary Care Strategy.

- Pro-actively undertake workforce analysis at regular intervals to inform the workforce plan achieving a multi professional workforce. The plan should be owned at practice group/locality level and due consideration given to the recruitment, retention and development of personnel across all staff groups.
- Regularly review training and development needs spanning all staff groups to ensure identified needs and skill mix are reflected in workforce plan(s), overseen by the task and finish group.
- Ensure a strong correlation between skill mix and health care need through focussing on population health, prevention and innovative ways of delivering care to patients through multi-disciplinary team working with health and social care partners i.e. community teams, also including mental health therapists.
- Develop a recruitment programme to attract and recruit personnel to work in Wolverhampton offering the necessary training and development to train them locally in the city, this also includes trainees and development of existing employees.
- Encourage and support those living in the area with suitable qualifications to work in primary care, maximising their employment potential i.e. hours, working at scale and seven day working.
- Establish and maintain strong links with stakeholder educational establishments to aid implementation of the strategy and achievement of a sustainable primary care workforce.
- In response to the General Practice Forward View work closely with the Black Country STP to respond to a range of projects and approaches on an STP footprint to secure value for money and greater quality through at scale development and delivery
- Develop a portfolio of educational events and oversee delivery of educational events for both medical, nursing and non-clinical staff groups, linked to the Workforce Strategy. Draw upon the expertise of the Comms Department to support the planning of engagement and events.
- Through work with practice groups/localities create a working environment that encourages trainees to remain in Wolverhampton
- Develop a primary care workforce dashboard based on the principles of the Primary Care Workforce Strategy and General Practice Five Year Forward View to routinely monitor the progress and identify early warnings where shortfalls/risks affecting the workforce can be identified and mitigated at the earliest opportunity.
- Provide assurance in the form of highlight reports or workbook updates to the Primary Care Strategy Committee following each Task and Finish Group Meeting.
- Identifying and securing resources internal and external to WCCG to support the implementation of the strategy through strong partnership working.
- To ensure sound information sharing among other task and finish group leads to aid effective implementation of the Workforce Strategy and strong allegiance with wider implementation of the Primary Care Strategy.

## **7 Reporting**

- 7.1 The Task and Finish Group will report to the Primary Care Strategy Committee/ Board following each meeting providing a formal update on all respective areas of the work programme.
- 7.2 Workstream leads will need to ensure they alert each other if implications for another workstream are identified (which will be reflected in the highlight report/workbook updates).

## **8. Review of Terms of Reference**

- 9.1 These terms of reference will be reviewed by the T and F group and Primary Care Strategy Committee annually to ensure the group is achieving its objectives and to ensure that key changes are being incorporated as required.

## **9. Terms of Reference Approval**

The Terms of Reference will be agreed within the Task and Finish Group as well as the Primary Care Strategy Committee/Board.

LR/SLS/TOR/V9/June17/FINAL

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**WOLVERHAMPTON CCG**
**Governing Body**  
**11 July 2017**
**Agenda item 17**

<b>TITLE OF REPORT:</b>	<b>Communication and Participation update</b>
<b>AUTHOR(s) OF REPORT:</b>	Pat Roberts, Lay member for PPI Helen Cook, Communications, Marketing & Engagement Manager
<b>MANAGEMENT LEAD:</b>	Pat Roberts – Lay member for PPI
<b>PURPOSE OF REPORT:</b>	This report updates the Governing Body on the key communications and participation activities in May and June 2017.
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This report is intended for the <b>public</b> domain
<b>KEY POINTS:</b>	<p>The key points to note from the report are:</p> <p><b>3. PPG chairs meeting leads from New Models of Care</b>  <b>4.1 Commissioning Intentions engagement</b></p>
<b>RECOMMENDATION:</b>	<ul style="list-style-type: none"> <li>• <b>Receive</b> and <b>discuss</b> this report</li> <li>• <b>Note</b> the action being taken</li> </ul>
<b>LINK TO BOARD ASSURANCE FRAMEWORK AIMS &amp; OBJECTIVES:</b>	
1. Improving the quality and safety of the services we commission	<ul style="list-style-type: none"> <li>• Involves and actively engages patients and the public. Uses the Engagement Cycle. – Commissioning Intentions.</li> <li>• Works in partnership with others.</li> </ul>
2. Reducing Health Inequalities in Wolverhampton	<ul style="list-style-type: none"> <li>• Involves and actively engages patients and the public. Uses the Engagement Cycle. – Commissioning Intentions.</li> <li>• Works in partnership with others.</li> <li>• Delivering key mandate requirements and NHS Constitution standards.</li> </ul>
3. System effectiveness delivered within our financial envelope	<ul style="list-style-type: none"> <li>• 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.</li> </ul>



## 1. BACKGROUND AND CURRENT SITUATION

- 1.1. To update the Governing Body on the key activities which have taken place in May and June 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 General Election – 8 June 2017

Due to the General Election 2017 on 8 June, communications outwards from the CCG and activity with the press has been limited and will continue until the period of purdah is closed.

#### 2.1.2 Press Releases

Press Releases since the last meeting have included; promotion for the Commissioning Intentions engagement events, Bank Holiday Extended GP opening and pharmacy opening hours and advice following the cyber attack.

### 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 Practice Nurse Bulletin went out in mid May. Topics included: Docman EDT Hub information, Primary Care Workforce Fayre, Post Reg nurse training, health channel on WIN, smoking in pregnancy pilot and a safeguarding app.

#### 2.2.3 Practice Managers Forum

The PM Forum planned sessions covered the following topics:

- Wolverhampton Information Network (WIN) – health section
- PCSE (Primary Care Support England) updates and news
- Social Prescribing
- Carers support update and presentation
- Patient Choice presentation
- Care Navigating training
- Compton Hospice Compassionate Communities & Partnership Development

#### 2.2.4 Annual Report

The Annual Report was signed off by the Governing Body and Auditors in late May and was published on the website on 12 June.

We are now in the process of preparing an Annual Report Summary ready for the AGM in July.



### 2.2.5 Annual Report Summary

We have begun work on the content of the Annual Report Summary. This will be printed and available at the CCG Annual General Meeting.

### 2.2.6 Annual General Meeting

We have begun planning for the AGM and sent out the invitations. The AGM will be held on Wednesday 26 July 2017, starting at 2pm in The Hayward Suite, Molineux Stadium. WV1 4QR. All are welcome to attend.

## 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. GP leads for the new models of care have been meeting with their network PPG Chairs to allow information on the new models, and provide an opportunity for the Chairs to ask questions. All the new groupings have decided to meet on a regular quarterly basis.

## 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

The 2017 Engagement Commissioning Cycle events were held on June 14/15/16. The sun shined down on us and it was a success as we were able to have conversations with over 300 people at four venues across the city. We used a double decker bus to attract the public and offered free health checks and information on Patient Choice too. Staff from all departments of the CCG helped with the public engagement.

The information from the conversations will be used to inform Commissioners about public views on health care services across the city.



### 4.2 Patient Groups

The Patient Participation Group/Citizen Forum meeting was held on 16 May. The Chairs informed the meeting about the issues they experience, some are still experiencing new member recruitment problems and we are trying to assist with this and will be helping with ideas for the set - up of Virtual groups in the future. Andrea Smith gave an update on BCF and Nick Carey an overview of the Wolverhampton Information network (WIN). Sarah Southall updated the group on Primary Care and answered questions from the floor.

- 4.3 **Health and Wellbeing cancer event**  
This well attended event in June was planned by Macmillan and Lesley Fellows for the CCG. It had a very varied agenda on diet, exercise and survivorship, and was well received. There will be a follow up event in October.
- 4.4 **CCG Falls Prevention Event**  
This workshop was held in June. The event is looking for information from the public about what they need to prevent falls.

## 5. KEY RISKS AND MITIGATIONS

N/A

## 6. IMPACT ASSESSMENT

- 6.1. **Financial and Resource Implications** - None known
- 6.2. **Quality and Safety Implications** - Any patient stories (soft intelligence) received are passed onto Quality & Safety team for use in improvements to quality of services.
- 6.3. **Equality Implications** - Any engagement or consultations undertaken have all equality and inclusion issues considered fully.
- 6.4. **Legal and Policy Implications** - N/A
- 6.5. **Other Implications** - N/A

**Name:** Pat Roberts  
**Job Title:** Lay member for PPI  
**Date:** 26 June 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 Patient and Public Participation in Commissioning health and social care.2017. PG Ref 06663



## 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	New Model of care Leads.	May/June
Public/ Patient View	CF/PPG chairs	May/June
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	
<b>Signed off by Report Owner (Must be completed)</b>	<b>Pat Roberts</b>	<b>27 June 2017</b>



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**MINUTES OF THE QUALITY & SAFETY COMMITTEE HELD ON 11th APRIL 2017,  
COMMENCING AT 10.30AM, IN THE MAIN CCG MEETING ROOM, WOLVERHAMPTON  
SCIENCE PARK.**

<b>PRESENT:</b>	Dr R Rajcholan	-	WCCG Board Member (Chair)
	Jim Oatridge	-	Lay Member, WCCG
	Marlene Lambeth	-	Patient Representative
	Pat Roberts	-	Lay Member Patient & Public Involvement
	Sukhdip Parvez	-	Quality & Patient Safety Manager
	Steve Barlow	-	Public Health Representative
	Steven Forsyth	-	Head of Quality & Risk
	Vijay Patel	-	Business Officer
	Vanessa Whatley	-	HoN Corporate Support Services (RWT)
	Liz Corrigan	-	Primary Care Quality Co-ordinator
	Philip Strickland	-	Administrative Officer
<b>APOLOGIES:</b>	Kerry Walters	-	Governance Lead Nurse, Public Health
	Manjeet Garcha	-	Executive Director of Nursing & Quality
	Peter McKensie	-	Corporate Operations Manager

**1. APOLOGIES & INTRODUCTIONS**

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

**2. DECLARATIONS OF INTEREST**

No declarations of interest were raised.

**3. MINUTES & ACTIONS OF THE LAST MEETING**

3.1 Minutes of the 14<sup>th</sup> March 2017

The minutes of the meeting held on the 14<sup>th</sup> March 2017 were approved as an accurate record with the exception of the following amendments:

Page 5 paragraph 4 should read as 'fractured neck of femur' in replacement of 'fracture of the neck'.

Page 5 paragraph 5 should read that 'BCPFT had considered attendance' in replacement of 'had initially declined'.

Page 6 paragraph 5 should read that 'the home was currently in a period of transition' to replace that the home was in a 'state of flux'.



### 3.2 Action Log from meeting held on the 14<sup>th</sup> March 2017

#### Sourcing of Patient Stories

SF stated he did not have a specific update in relation to the action for MG in relation to the sourcing of patient stories however SF did highlight that the submitted Monthly Quality Report did include a new Patient Story.

PR believed that there needed to be a full written process for the sourcing and use of Patient Stories at Committees and the Governing Body. PR also added that it would be important to incorporate into any written process the feeding back of negative and positive feedback from a specific story back into the system.

SF reported that the use of patient stories did feed into the complaints process. PR questioned whether this incorporated soft intelligence and anonymous patient stories.

## 4. **MATTERS ARISING**

ML highlighted to the committee that she had recently attended dermatology as a patient. ML felt the experience as a patient had not been overall positive. ML highlighted that the doctor she had seen in dermatology had not been able to communicate effectively in English. ML added that the process of the reason behind a biopsy that had been taken was not clearly explained. SF requested that ML share the detail of the appointment and the Quality Team would follow the issues up with the department. ML requested that this be followed up after the results of the biopsy had been received.

## 5. **ASSURANCE REPORTS**

### 5.1 Monthly Quality Report

#### Royal Wolverhampton Trust

SF highlighted from page 3 of the report that the Serious Incident information contained not only included the figures in a bar chart form but also a breakdown of information regarding each of the incidents. SF was keen to stress that the information contained was from initial reporting only and each incidents would still be awaiting the outcome of each Root Cause Analysis (RCA). SF highlighted from the information provided that 2 of the patient falls reported had been attributed to ward A8 which the Trust had placed into special measures. SF confirmed that the ward had been having greater scrutiny placed upon it whilst also having additional support.

SF highlighted that RWT had developed a strategy to combat Carbapenemase Producing Enterobacteriaceae (CPE) which included a business case for molecular testing in the Trust laboratory, full implementation of a risk assessment and screening process and executive level awareness raising sessions. SF added that this had been in response to a rise in the prevalence of CPE nationally.





SF confirmed that SP continued to attend the Pressure Injury Scrutiny Group. SF stated that discussion had taken place with the Trust around how work progresses on reducing pressure injuries across the health economy through collaborative working in 2017/18. It was highlighted that this would include training for domiciliary care staff. PR highlighted that collaborative working would be a positive step but then raised concerns that at present there had not been a clear reduction in pressure injuries but rather containment. PR believed that a leaflet for patients detailing how they can effectively spot pressure injuries on their own skin would be useful across the whole health economy. SP did wish to note that RWT and the district nurses do provide the patient with a leaflet of this nature. SF stated that although pressure injuries are increasing the avoidability of PIs is reducing. RR enquired when the wound centre for excellence would be up and running? SP stated that Karen Evans was leading on this piece of work alongside RWT and further updates on this were to follow.

SF confirmed that the never event that had been reported at the last QSC verbally had been accurate and was contained in the submitted monthly report.

JO enquired what the current position was with regard to mortality at RWT? SF reported that the HSMR indicator for July 2015 to June 2016 had placed RWT as an outlier for mortality rates which had been due to a special cause variation with processes such as coding or pathways being identified. SF stated that RWT had undertaken a comprehensive internal mortality review to understand the issues further. SF stated that the reviews that had been undertaken had not found any failings in care that would have led to avoidable deaths. SF continued that the additional assurance that had been made are that RWT are an early adopter of the RCP national methodology review and consultant outcomes are also higher than the national averages. SF added that there would also be 3 further external reviews, 2 of which were confirmed as being undertaken by RWT covering coding and a case note review and 1 by the CCG/CSU to conduct a pathway review all of which was confirmed as being agreed by NHSI and NHSE.

### BCPFT

SF reported that there had been 2 SI's reported for the month of March 2017, it was noted that the quality team were currently awaiting the outcomes of the RCA.

SF highlighted that there had been conflicting opinion between the CCG and BCPFT regarding a Pressure Injury SI. It was noted that the CCG had noted the PI as avoidable however BCPFT had deemed the PI 'unavoidable'. SF confirmed that this had been escalated to NHSE and it was also noted that BCPFT had also undertaken another table top review. SF stated that the CCG had queried the version control and the content of submitted action plans.

### Vocare

SF confirmed that Vocare had been visited by the CQC on the 24<sup>th</sup> March 2017. SF stated that the details of which were contained within the submitted report relating to the significant concerns raised and at this stage were confidential. SF stated that the concerns raised had been in line with concerns already raised by the CCG. It was noted that the Accountable Officer Dr Helen Hibbs had met with the Chief Executives of Vocare to discuss concerns. SF confirmed that following the CQC visit and the board to board meeting, the CCG had invited the CQC, NHSE, Vocare, and the key associate



commissioners to an improvement board meeting. On-going issues and actions with Vocare were documented in the submitted report.

PR did highlight from the report that Vocare did not just provide an 'Out of Hours' service and therefore PR requested that the title of the specific section in the monthly report should be amended.

#### OFTED Visit

SF confirmed that following the recent OFSTED visit a rating of good had been achieved.

#### Probert Court

SF and SP highlighted to the committee that Probert Court had currently been working on a robust action plan to improve the medicine management practice and is closely monitored and supported by WCC's Quality Team. It was added that Probert court had raised a few QIL's about inappropriate patients transferred to them from RWT and this had significantly impacted on their service delivery, which had potentially put patients at risk. SP added that these QIL's have now been escalated to an Executive level and would be managed and monitored accordingly through the Probert CQRM.

SF wished to add that the CCG are receiving bi-weekly updates and are monitoring the on-going situation.

#### General Update

SF wished to highlight to the committee that the Quality Team was currently depleted in numbers due to varying reasons during a very busy period.

#### Patient Story

SF confirmed that the submitted patient story was very much a positive news story. SF stated that the story had been shared with the Chief Nurse of RWT. PR enquired if the positive feedback had been shared with the patient concerned. SF stated that he felt it was appropriate to write out to the patient on behalf of the committee. PR questioned whether this story would be fed through to the Governing Body. JO stated that the story would be welcomed by the Governing Body however it would be important to maintain a balance between good news and bad news stories.

**Action:** *RR to write to the patient on behalf of the committee to thank them for sharing their patient story.*

#### 5.2 Information Governance Quarterly Report

Following a comprehensive update at the last QSC this item had been deferred until the next scheduled Quarterly update.

#### 5.3 Freedom of Information Report



Vijay Patel was in attendance to present the Freedom of Information Report for period 1<sup>st</sup> January to 31<sup>st</sup> March Quarter 4. VP confirmed that the CCG had 81 Freedom of Information requests. VP added that at the time of writing the submitted report the CCG had responded to 75 of the requests, all of which had received a response within the statutory 20 working days. It was noted that of the six requests awaiting responses are all still within the 20 day timeframe (one request is awaiting clarification from the requestor) and the CCG expect to provide a response in line with the requirement. The committee noted that this had been the first quarter that 100% of requests had been responded to within the extended timeframe.

VP confirmed that for the year overall, the CCG has received 282 requests, 97% of which had been responded to within the statutory timescale. The CCG had not received any requests for review of FOI decisions or been subject to any complaints to the Information Commissioners Office during the year.

SF enquired how many FOI's would then be followed up with a further FOI and also if the CCG are asked a question can the question then be re-asked in a differing way? VP stated that until this point there had never been a return query of that nature. SF also asked whether there had ever been an FOI that had subsequently led to a negative press release? VP again stated that this had not been the case.

JO endorsed that in 2.3 of the report were it stated that 'Although FOI requests may be made by anyone and the CCG response does not differ based on the source of the request' that this was absolutely essential in holding a firm line in dealing with pure facts.

VP confirmed that if a requestor is not content with the response received they can write back to the CCG and the 20 day clock would be applied again as with a new request for information as opposed to an appeal. JO highlighted in other organisations there is a process in that appeals can be made to a nominated appeals chair person before they then approach the information commissioner. JO therefore believed that as an organisation perhaps it should be considered that an appeals option should be given as opposed to treating repeat queries as a new request.

#### 5.4 Board Assurance Framework and Risk Register

SF stated that the submitted report was the first presented in the format shown to QSC. The report is to go to the Audit and Governance committee next week and further updates will follow.

Queries were made by the committee as to why Patient Choice had been noted as an extreme risk. SG stated that further detail would follow on this in the next report.

#### 5.5 Health and Safety Performance Report

The submitted report was noted for information by the committee.

#### 5.6 National Report and Enquiries



The submitted report was noted for information by the committee.

### 5.7 Infection Prevention Report

Vanessa Whatley the Head of Nursing - Corporate Support Services for RWT was in attendance to provide the Infection Prevention Quarterly report to the Committee for Quarter 4.

VW did highlight to the committee that the national data sets do not close down until the 15<sup>th</sup> of every month and therefore some of the submitted data is not wholly complete and therefore data within the report for March 2017 was therefore provisional.

VW confirmed that the GP 'Enhanced Standards' had been updated which underpinned the audit process for General Practice. It was added that those standards would be operational from 1st April 2017 in vertically integrated practices. The CCG had the document for consideration for use in other practices and VW stated that the Trust were hoping for the confirmation to use the new documentation. SF requested that the new documentation be forwarded to the next QSC in May 2016 for sign off by the committee. VW did highlight that the new documentation would dramatically reduce the scores for practices.

**Action:** *The new GP enhanced standards are to be considered at the May 2017 QSC. VW was requested to attend.*

VW confirmed that Four GP practices were currently receiving individual support to improve Infection Prevention standards/compliance. VW highlighted that this support would sometimes be requested by the practices.

VW confirmed that there had been no cases of MRSA reported for Quarter 4. VW also added that the 1 case reported last year was in the end attributed to a care home meaning that it had officially been 2 years since the last reported case of MRSA. It was also noted that more widely across the area the numbers reported had been the lowest that they had ever been reported due to a combination of work relating to effective screening. It was noted by the committee that MRSA screening in care homes had now ceased.

VW reported that WCCG C-Difficile requirement for 2016/17 was a maximum of 71 cases. The committee noted that the CCG ended the year on 58/71 (provisional data as of 31/03/2017).

It was confirmed that in line with the joint working between the CCG and Public Health it was highlighted that there were 8 cases of suspected Noro-Virus of which 5 were confirmed, 3 flu outbreaks and 1 case of scabies.

VW sighted the committee on a prevalence project in Appendix one of the submitted report in which it analysis's the prevalence of infection in patients in care homes at any one moment in time. The committee noted the contents of the data. Indeed it was highlighted that the relationship between infections and patients mobility status remained a running theme with those that are most dependent (require hoisting) having the majority of infections (54%).

VW added that the group had discussed action related to Urinary Tract Infection and the possible co-ordinated implementation of Public Health England's Urinary tract infection: diagnosis guide for primary care and supporting education.

VW also highlighted a further project in relation to Long Term Urinary Catheter usage. It was noted that approximately 600 people have a long term urinary catheter at any one time in Wolverhampton. The on-going project has now progressed to review all of these people for the reason for their catheter, to move them, where clinically possible to the previously launched preferred list of catheters and, where possible, seek discussion on catheter removal. The committee noted that previous investigation had shown 28 day mortality to be high in the group admitted due to complications with catheters. 2-3 patients per month had been admitted with sepsis secondary to urinary catheters though these are not all from Wolverhampton.

SF requested that whilst VW was present at the committee could any assurances be given around the work relating to CPE as highlighted in the Monthly Quality Report. VW stated that the Trust had a policy in place that had been constantly being reviewed as encounters with CPE occur. VW confirmed that there had been deaths nationally as a result of this and are treating cases with a variation of Anti-biotics however there had been pan resistant cases. CPE spreads predominantly like any other infection and prevention relating to good hand hygiene and cleaning are standard preventative methods. VW stated that prevention and treatment would be very reliant on good Anti-biotic stewardship. It was also added that an effective method of screening had been implemented. It was highlighted that the national toolkit for CPE had now become out dated and the Trust had approached Public Health to see if the toolkit would be updated. SF suggested that a joint letter be drafted to Public Health from the Quality & Safety Committee and RWT to highlight that the toolkit was out of date.

**Action:** *A joint letter is to drafted from the Chair of QSC and RWT to Public Health in relation to the CPE Toolkit.*

## 5.8 Primary Care Quality Report

Liz Corrigan - Primary Care Quality Co-ordinator was in attendance to report to the committee in relation to Quality in Primary Care. LC highlighted that the report that had been submitted was the report that was also submitted to the Primary Care Operational Management Group on a monthly basis. LC stated that one of the main areas that had been monitored on a monthly basis had been the Friends & Family Test Data. LC confirmed that with full delegation the responsibility for FFT now lay with the CCG and not NHSE. LC stated that all submissions are submitted 2 months in arrears and therefore April's data would be from February. Data from March had highlighted that the amount of people that would recommend their GP had significantly reduced. LC stated it was not totally clear at present the reason for the reduction at this stage but there will be further analysis made when another month's worth of data had been collected.

PR raised a concern in relation to the numbers of practice not submitting data for FFT. It was noted that 22 practices had either not submitted or were reporting nil responses which accounted for nearly half of the local practices. LC wished to highlight that now the CCG had taken control of this from NHSE the CCG could have a greater input in creating better outcomes for FFT. LC wished the committee to note that the lack of data from some practices may have been the result of technical issues however this was currently being



investigated. LC highlighted that at present a lot of the data is very quantitative based and the CCG will be pushing to incorporate some qualitative data also.

It was noted from the report that there were currently 4 new Quality Matters open for Primary Care. LC added that 1 of the Quality Matters included an IG breach. PR stated that it had been highlighted at the CCG PPG meeting that some practices were not aware of how to correctly blind copy an email. LC and SF felt that perhaps some communications could be sent out regarding IG breaches and perhaps it could also be raised at Team W.

LC confirmed that NHSE would continue to manage complaints.

LC stated that the NICE assurance group met on the 15th February 2016 where the latest guidelines were discussed.

From the report it was that 3 CQC visits reports had been published in Primary Care for March 2017. Whitmore Reans was confirmed as continuing to be monitored following a 'Requires Improvement' rating.

LC highlighted that there were currently 2 extreme red risks of which one is around Mass Causality Planning which Tally Kalea was currently managing within the CCG. PR believed that Emergency Preparedness should have a standard business continuity template for all practices to follow. RR had the understanding that each practice should be arranging this individually. SF stated that clarity was required on this.

LC added that the 2<sup>nd</sup> of the extreme risk was in relation to data transfer of child data between systems which had caused people to miss appointments. Public health were confirmed as monitoring the data.

LC stated that the workforce fair was still in the final planning phase with a tentative date of late May/early June 2017.

It was added that GP Forward view programmes including administrator training and practice manager development have commencing

LC confirmed that work around training and workforce analysis for the PCH and VI practices is being planned for April.

## 6. RISK REVIEW

## 7. ITEMS FOR CONSIDERATION

### 7.1 Terms of Reference

The ToR were noted for information by the committee. SF welcomed any comments outside of the meeting.



7.2 BCPFT Quality Annual Report

SF welcomed any comments in relation to the Annual Report.

7.3 Quality & Safety Committee Draft Annual Report

PMc was not in attendance but if the committee had any questions they can be directed to PMc outside of the meeting.

**8. POLICIES FOR CONSIDERATION**

8.1 Policy for the Notification of Serious Incidents in Commissioned Services

The policy changes were noted by the committee.

**9. FEEDBACK FROM ASSOCIATED FORUMS**

9.1 Draft CCG Governing Body Minutes

The minutes were noted by the committee.

9.2 Health & Wellbeing Board Minutes

The minutes were noted by the committee.

9.3 Quality Surveillance Group

The minutes were noted by the committee.

9.4 Primary Care Operational Management Group

The minutes were noted by the committee.

9.5 Draft Commissioning Committee Minutes

The minutes were noted by the committee.

9.6 Pressure Injury Steering Group.

No minutes were available for the meeting.



**10. ITEMS FOR ESCALATION/FEEDBACK TO CCG GOVERNING BODY**

It was agreed that it would be raised at the Governing Body regarding the use of patient stories moving forward.

**11. ANY OTHER BUSINESS**

No further items were raised by the committee.

**12. DATE AND TIME OF NEXT MEETING**

- ***Tuesday 9<sup>th</sup> May 2017, 10.30am – 12.30pm; CCG Main Meeting Room.***





**MINUTES OF THE QUALITY & SAFETY COMMITTEE HELD ON 9th MAY 2017,  
COMMENCING AT 10.30AM, IN THE MAIN CCG MEETING ROOM, WOLVERHAMPTON  
SCIENCE PARK.**

<b>PRESENT:</b>	Dr R Rajcholan	-	WCCG Board Member (Chair)
	Jim Oatridge	-	Lay Member, WCCG
	Marlene Lambeth	-	Patient Representative
	Pat Roberts	-	Lay Member Patient & Public Involvement
	Steve Barlow	-	Public Health Representative
	Manjeet Garcha	-	Executive Director of Nursing & Quality
	Steven Forsyth	-	Head of Quality & Risk
	Jodie Winfield	-	Nurse Manager IPC (RWT)
	Liz Corrigan	-	Primary Care Quality Co-ordinator
	Peter Price	-	Independent Member
	Molly H-Dillon	-	QNA Team Leader
	Philip Strickland	-	Administrative Officer
	<b>APOLOGIES:</b>	Kerry Walters	-
Sukhdip Parvez		-	Quality & Patient Safety Manager
David Birch		-	Head of Medicines Optimisation

**1. APOLOGIES & INTRODUCTIONS**

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

**2. DECLARATIONS OF INTEREST**

No declarations of interest were raised.

**3. MINUTES & ACTIONS OF THE LAST MEETING**

3.1 Minutes of the 11<sup>th</sup> April 2017

The minutes of the meeting held on the 11<sup>th</sup> April 2017 were approved as an accurate record with the exception of the following amendments:

SB highlighted from page 4 paragraph 3 that there should a differentiation between the OFSTED visit and the update given regarding Vocare. The master copy of the minutes would be amended.

PR highlighted that page 2 paragraph 3 should include an update that states that '.....patient stories should be allowed for due to a patient's fear of retribution from the service.'



JO highlighted that page 5 paragraph 5 should indicate an action for PMc to pick up whether the organisation should consider an appeals process opposed to treating repeat FOI requests as a new request.

**ACTION:** *PMc to consider whether the organisation required an appeals process for FOI's.*

SB wished to highlight that the CPE toolkit letter mentioned in the minutes should be forwarded to Public Health England.

### 3.2 Action Log from meeting held on the 11<sup>th</sup> April 2017

Key actions from the action log were discussed as follows and an updated version of the action log would be circulated with the minutes:

#### Litigation Complaints

SF reported that the detail in relation to the number of complaints that end in litigation was currently not yet available but would be contained in the next monthly report once it had been made available. It was noted that the data was collated from the themed review that is provided by the provider at CQRM. PR stated it would be interesting to find out the number and also the amount that it costs organisations. MG stated that there was very little information shared from the NHSLA litigation authority on this and all information would be required direct from the providers.

#### Harm Reviews

SF stated that there had been discussions at CQRM regarding harm reviews. It was noted that there was a harm review report due at the last CQRM that wasn't provided however the Trust provided a verbal update on the 104 day cancer wait patients. The expectation of the CCG hadn't been delivered upon. It was agreed in the meeting that perhaps a one line update in the Trusts IQPR relating to RCA's being conducted on all 104 day cancer waiters. SF continued that following the CQRM in April NHSE had written to MG and SF asking how the CCG would be monitoring providers on their 104 day cancer breaches and whether an RCA would be completed. MG stated that NHSE had requested a response from the CCG, however it was unclear as to whether the NHSE had requested this from the CCG only or across the area. MG stated that discussions had subsequently taken place between the Trust and the CCG. It was highlighted by the Trust that they would not wait until 104 days to conduct a RCA and this would be picked up at an earlier stage at a multi-disciplinary team meeting. MG continued that if at those meetings a patient health was deteriorating they would be fast tracked through the system. It was noted that the 4 patient that were currently outstanding at RWT were very complex patients. It was also discussed by the committee of the importance of relaying communication back to the patients GP.



### Patient Story

It was confirmed that a letter was distributed to the patient's family to thank them for sharing their story. The letter also offered an invitation to the family to attend a Governing Body for them to share their story in person.

### CPE Toolkit Letter

It was noted that a letter had been drafted jointly between the CCG and RWT to be forwarded to Public Health England.

## **4. MATTERS ARISING**

### 4.1 Wound Centre for Excellence - Verbal Update

SF confirmed that they were still awaiting figures for the business case from commissioning. SF stated that this had been discussed at the Better Integrated Care meeting held recently. SF stated that a further update would be to follow.

**ACTION:** ***SP to provide an update on the Wound Centre for Excellence at the June 2017 QSC.***

### 4.2 GP Enhanced Standards

Jodie Winfield was in attendance to discuss GP Enhanced Standards to the committee. JW confirmed that the standards were due for review and the aim was to strengthen on those standards. Indeed it was noted that the current GP enhanced standards and audit tool was used to audit compliance with Infection Prevention Standards which required an update in order to bring them in line with key national standards and guidelines.

It was noted by the committee that there is a risk that GP practices would fall behind national standards through not keeping abreast with current guidance. The submitted report detailed the areas that would be made in terms of improvement and is looking at whether the CCG wish to adopt these standards across all GP practices in Wolverhampton.

JW highlighted that the main areas of improvement had been in relation to mechanical ventilation in minor surgery, including a clean store room, a deeper scrub sink specifically for minor surgery, and appropriate facilities for disposing of waste water. JW stated that many of the building were not set up in such a way as to be compliant with the standards. JW stated that the organisation wish to aim for a 'gold' standard and aspire to have the best possible facilities.

JW highlighted that the report acknowledged that some standards were still not compliant and there is a recommendation that risk assessments should be made to identify were improvements needed to be made.



It was discussed as to the cost of the improvements, and JW highlighted that a costing exercise could be undertaken once the audits are complete next April 2018 with each individual practices. JO stated that it would be useful have a time line for implementation of this process.

MG added that one of the key issues for practices would be whether they have the physical space to incorporate the changes. JW stated that the report highlighted what constituted minor surgery. MG advised that this report should attend the Primary Care Operational Group.

## 5. ASSURANCE REPORTS

### 5.1 Monthly Quality Report

#### Primary Care

LC was in attendance to provide the Primary Care update for the committee. LC highlighted to the committee that the IP audit ratings had been completed and the ratings were highlighted in the report.

LC stated that data that was requested for practices that were not returning FFT data has been included in the submitted report. The data contained in the report for April 2017 is based on figures from February 2017. LC confirmed that 10 practices did not respond with any data. It was stated that this appeared to be the average judging on the 'nil' returns from the previous few months. LC added that 5 practices had data suppressed due to returns less than 5. LC stated that the overall figure meant that 38% of practices had no data allocated to their practice.

PP enquired what the frequency of submission had been? LC confirmed that the figures are collated on a monthly basis. PP believed that the data would be more effective if it was collated on a quarterly basis. LC stated that there was currently discussion on-going regarding taking FFT to a 'Team W' session to inform the practices that the CCG now have oversight of FFT. LC stated that the non-submission of data could also be raised at the New Models of Care Group and also with the PPG chairs. It was noted by the committee that some of the nil returns received could be a system issue.

PP questioned whether the process was less important than analysing the data that read as Extremely Unlikely. LC stated that this would be the next focus once the process was fully up and running and effective data was being submitted. LC added that the extremely unlikely data would be analysed not just in number but also on the written responses by the patients. It was noted by the committee that 28% of the data received is written, 32% is received via text, and 20% is via the tablet screen used for checking patients in to surgery. PP wondered if surgeries were using the feedback to help improve processes at the individual practices. LC added that it would be important to triangulate data with what patients had been writing onto NHS Choices.

MG wished to confirm that if there were any issues raised here at the QSC whether those are then picked up through the Operational Management Group. LC indeed confirmed that this was the case.

LC confirmed that the Primary Care Workforce Fayre was to take place on the 15<sup>th</sup> June 2017 taking place at the Science Park. It was noted that this would incorporate a morning and afternoon event covering all areas of Primary Care recruitment. LC stated that there



would be visiting speakers from the local University, Health Education England and the Deanery.

MG enquired were the Workforce Fayre would be advertised. LC confirmed that the Fayre would be advertised locally through the communications team onto local newspaper and radio, through the local University, the Deanery, and Health Education England. LC also stated that she had been provided some information from Philip Strickland regarding avenues of recruitment through the Armed Forces resettlement teams. LC stated that the Fayre was aimed at all backgrounds and skill sets. MG highlighted that part of the battle in attracting GP's are the neighbouring areas that are offering financial incentives to move to a certain area, which it was noted the CCG would not be offering. LC stated that Dr Salma Reehana had been supporting in the agenda for the GP recruitment element. The CCG are looking at other elements of attraction for GPs including training opportunities. LC confirmed that a 'Video' is being work on relating to the attraction of living in the local area.

### General Quality Update

SF wished to sight the committee on a confidential matter relating to an individual involved in court of protection proceedings. MG stated that this was indeed a very complex case and the CCG were working alongside the Local Authority. It was felt that the content of the update was of a confidential nature and at this stage should be omitted from the contents of the minutes.

SF provided again a further confidential update relating to a local care home that was being monitored following some statistical intelligence. Again it was noted by the committee that this update should at this stage be omitted from the minutes.

### Royal Wolverhampton Trust

SF reported that it had been identified as part of a recent RCA that there were currently 4000 X-rays and 1000 MRI and CT scans overdue. SF confirmed that the CCG had written to New Cross contractually to identify the reasons for the backlog and how the Trust was to address the situation. MG wished to clarify that the X-Rays and MRI's had taken place but had not been reported upon. It was confirmed that 585 of those related to Wolverhampton GPs. SF confirmed that the Trust had employed 2 radiographers to work through the backlog and the Trust had confirmed that the backlog would be cleared by the end of July. SF stated that the CCG enquired whether there would be any clinical risk as a result of the backlog. The Trust had batched the backlog into urgency categories.

MG enquired whether GPs have the choice of requesting a scan as priority or routine? RR stated that there was not a choice of as kind for a scan urgently however RR confirmed that she would write in bold at the top of the request that a scan was needed urgently. RR had been impressed at the recent CQRM that a Cannock GP Dr Staite had been receiving results the same day however RR added that in her experience results could take between 7-14 days. RR stated that since the recent CQRM the turnaround for results had improved to the same day or the day after the request. MG stated that assurance was required from the Trust regarding scans that contain urgent concerns being fast tracked through the system. SF added that just to add some context to the issue it was raised at CQRM that the Trust were still meeting national targets even with the backlog. It was noted that in effect the numbers contained in the backlog were a small number in comparison to the overall numbers of scans that take place. JO raised a concern that the Trust had not highlighted this to the CCG prior to the CCG discovering that there had been a backlog



through another incident. MG confirmed that the CQRM now contained 'Duty of Candour' on the agenda giving the Trust the opportunity to disclose any issues that the Trust need to disclose to the CCG. PR confirmed that she had received some soft intelligence from BCPFT that the Healthy Minds waiting times were incredibly large and PR raised a concern as to why the CCG had not been aware of it.

SF wished to raise an issue with the committee regarding a fall that had taken place on C19 in January 2017 which then formed part of a police investigation and a safeguarding referral. SF stated that particular case had now been to coroners court in which the coroner reported an accidental death. Subsequent to this the coroner had issued a Regulation 28. SF stated that one of the themes raised from the inquest had been around junior staff being able to challenge senior staff on certain issues. SF stated that that there had been a timeframe set for the Trust to respond to the Coroner. SF confirmed that the RCA from the incident was to be discussed at the CCGs internal SISG meeting within which the local authority social worker from the MASH team had been invited to attend.

### Serious Incidents

SF wished to highlight to the committee the types of incidents that were coming through. SF stated that it was highlighted on page 10 of the report that a Never Event had taken place and the CCG were awaiting a response from the Trust. It was noted that the incident had involved a locum doctor. JO stated that the never event commentary stated that there had been a failure to review a chest x-ray but also that there had been a Locum doctor present undertaking the procedure. Indeed JO believed that commentary alluded to the fact that this had occurred due to it being a Locum Doctor. JO stated that Locum doctors are trained and therefore this should not be deemed acceptable as an excuse for the Never Event.

MG highlighted from the report that it was important to differentiate between MRSA bacteraemia and MRSA skin colonisation.

PR highlighted from Page 4 of the report in relation to a neo-natal death of a baby being transferred from Stoke to New Cross Hospital. PR enquired if the mother had travelled across with the baby? SF stated at this stage this had not been made clear.

### Maternity

SF stated that a discussion had taken place at the April RWT CQRM in that the numbers of births taking place at Wolverhampton had increased this had been as a result of taking mothers from other areas including Walsall and Shrewsbury and Telford. The CCG commissioning manager would be holding a meeting to address this issue. SF stated that NHSE had been sighted on the issue. SF continued that the Trust had a plan in place to address the numbers of births. MG confirmed that the midwife to birth ratio was currently at 1:31 while the national average was at 1:28. It was also noted that the midwife vacancy rate was at 4.3% and the sickness rate was at 7.3%.

### Mortality

SF confirmed that Dr Odum (Medical Director RWT) had been requested to attend CQRM in May to give an overview of to the recently submitted Mortality report that the Trust had produced. SF stated that the report had been difficult to interpret and it had been felt that the overview of an expert was required. SF added that the CSU are also reviewing the



report on behalf of the CCG. It was noted that the Trust were conducting an internal review initially. MG confirmed that a company named CHKS were in the Trust to audit coding, and AY Consulting are in the Trust to undertake a case note review of 20 case notes. It was confirmed that Dr Julian Parkes would be attending Mortality Review Groups as a representative of Primary Care. JO enquired whether it would be appropriate for Dr Parkes to be the representative for Primary Care when Dr Parkes was now in fact an employee of RWT. PR stated that perhaps it should be an independent representative who attends. MG advised that his capacity at the meeting was purely to advise on the patient journey.

**ACTION:** *PR requested that the PCOMG advise on the way forward in terms of Dr Parkes attendance as a Primary Care representative at Mortality Review, as Dr Parkes was now officially an employee of RWT*

### BCPFT

SF stated that the key issues from BCPFT were contained in the report. However SF wished to highlight to the committee that BCPFT did not believe that CPA applied to patients with a learning disability. SF confirmed that this had been urgently rectified.

### Vocare

SF confirmed that the 1<sup>st</sup> of the Vocare improvement boards had taken place. SF stated that it had been disappointing that the CQC were not able to attend. SF stated that work with Vocare was indeed progressing and there is a consolidated action plan expected for the next improvement board which included 150 actions.

It was noted that there were some further actions picked up from the Vocare CRM in that their Quality report had listed all of their incidents of which 15 had the potential to be identified as serious incidents. A meeting had been arranged to review those incidents.

### Point of Care Foundation

SF wished to highlight to the committee that the Quality Team had been shortlisted to be part of the Point of Care Foundation. SF wish this to be commended following a long and arduous application process.

JO wished to highlight that perhaps the report moving forward should have a cover sheet highlighting the key topics that the committee are wished to acknowledge. PR also stated that the new Committee and Governing Body template coversheet does now have a section for this purpose.

## 5.2 Safeguarding Adults Quarterly Report

AL was in attendance to present the Quarter 4 Safeguarding Adults report. AL confirmed that WCCG was a statutory member of the Wolverhampton Safeguarding Board in which AL attended on behalf of MG. A summary of the key discussions were highlighted in the submitted report. AL confirmed that the CCG would be heavily involved in the Safeguarding Week due to be held on the 12<sup>th</sup> June 2017. It was also noted that Changes to Pre Charge Bail (Police and Crime Bill 2016) had been presented at the board. The details of which were contained in the appendix of the report submitted.



AL confirmed that at present there was currently one DHR in process and 2 that could potential be DHR's.

It was noted that key findings from analysis of Domestic Homicide Reviews had been published by the Home Office in December 2016. A summary of the findings could be found in appendix 2 of the report. This had been circulated to Primary Care in the GP Safeguarding Bulletin, a link had been added to the WCCG Intranet page for Safeguarding Adults and this would be integrated in to any future safeguarding training.

It was reported that £10,000 had been received from NHS England for CCG led Safeguarding projects. A project plan (in line with NHSE priorities) had been submitted to and accepted by NHS England by the Safeguarding Team. It was noted that the commissioning of a specialist drama group who will provide training for health professionals, with a focus on The Voice of the Child, Think Family and Making Safeguarding Personal. It was added that the training event will be held at the Science Park and 160 places will be available – the date were to be confirmed, anticipated to be in the summer of 2017. It was also reported that collaborative contribution to continuation of the MCA/DoLs project with Dudley and Walsall CCG's would form part of the money provided from NHSE (the evaluation of phase 1 of the project would be included in the Safeguarding Adults Annual Report).

AL stated that the end of year analysis of provider assurance will be contained within the Safeguarding Adults Annual report for 2016/17. It was also reported that the provider dashboard had been amended for the 2017/18 contract and work had been carried out by the safeguarding leads to embed the provider assurance reporting framework within the contracts.

### 5.3 Safeguarding Children and LAC Quarterly Report

LM noted apologies from Fiona Brennan who was not able to attend to present the LAC element of the report.

LM reported that the WCCG self -assessment contains a number of standards relating directly to Safeguarding Children. This was being reviewed on a quarterly basis. This showed 2 standards continuing to be rated as amber. LM stated that one of these related to Safer Working Practices and Until 2015 within the guidance there was no defined requirement to undertake regular DBS checks post-employment. The NHS has varying practices about post-employment checks in both criteria and frequency depending on the organisation practice and the role of the individual.

It was noted that as part of Recommendation 7 of the Lampard Report 2015 which stated that all NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers and would be by the CCG.

It was confirmed that the WCCG Designated Doctor for Safeguarding Children Unexpected Child Deaths left the organisation in April 2017. On-going discussions continued to place at Executive level and through contract teams to ensure the RWT identify a suitably trained and experienced individual to fill the role.





It was noted by the committee that the judgement of the recent Ofsted inspection of Children's Services in the City of Wolverhampton was published on 31.3.17 with Overall Judgement being 'Good.'

LM confirmed that the WCCG had developed and submitted an action plan as required, to address the recommendations from the visit of the CQC. This would be monitored by WCCG through a Strategic Group led by the Director of Nursing and Quality and CQC colleagues in the Central Region, who will determine the appropriate regulatory response.

LM reported that an extra-ordinary meeting of the WSCB was held on the 9th January 2017 to sign off the final overview report following the death of Child F in January 2016. The final report was due to be submitted to the DfE on 25th January 2017 with publication of the report planned for 3rd February 2017. However due to the concerns of the impact of publication on maternal mental health the publication was a delayed until April.

It was confirmed that the WCCG Safeguarding Children Administration Officers commenced in post in February 2017 and underwent an induction process to include an understanding of WCCG, LA, GP, BCPFT and the RWT processes and services to ensure they were able to fulfil their role effectively.

The contents of the LAC report was noted by the committee.

#### 5.4 Medicines Optimisation Quarterly Report

The contents of the report was noted by the committee. David Birch was unable to attend the meeting and any queries from the report should shared with David via email.

#### 5.5 Quality Assurance in Care Homes Quarterly Report

MHD reported that five stage 3 & 4 pressure injuries (PI) were determined during Q4 compared to same time last year when 10 avoidable pressure injuries were reported. 50% improvement in harms in relation to pressure injury acquired in the care home and reduction on Q3 when 7 avoidable pressure ulcers were reported. This demonstrated that the intensive support and training to the care homes in pressure injury prevention is having a positive impact.

MHD confirmed that thirty one safeguarding concerns were referred to the QNA team during the quarter. It was added that of those 6 were MASH (multiagency adult safeguarding hub) referrals and all 6 related to poor care delivery. MHD continued that Two of the 31 referrals related to PIs, 1 was regarding physical abuse and 28 were related to neglect/acts of omission the same as last quarter. Of these 2 safeguarding referrals most related to poor medicines management and poor care which included failure to carry out management plans.

The remainder of the report was noted by the committee.



## 6. RISK REVIEW

Dawn Bowden was in attendance to facilitate a Risk Review of the Committees risks on the organisations Risk Register. The risks were reviewed in real time through the online, on screen Datix facility.

DB highlighted that each risk had been aligned to one specific committee in line with the work conducted by Pricewaterhouse Coopers (PWC). DB highlighted to the committee that there were currently 3 extreme risks assigned to the committee.

DB stated that there were currently 5 risks assigned to Safeguarding however these were now being condensed into 1 over-arching risk by Lorraine Millard.

The committee enquired that the risk that related to patient choice which had been raised by Mike Hastings had been assigned to 3 separate committees as well as being rated as an extreme risk.

**ACTION:** *SF requested that DB clarify which committee the Patient Choice risk should be assigned to for the next meeting.*

*LM to review each Safeguarding risk into one over-arching risk before the next committee.*

*David Birch was requested to review the clinical pharmacist risk in time for the next committee.*

JO enquired whether the vacancy for the Named Doctor for Safeguarding should appear on the Risk Register. SF stated that this role was not a compulsory role however the CCG created the role and at this stage there was no need to add to the register. JO added that the role had been deemed essential in the submitted safeguarding report.

## 7. ITEMS FOR CONSIDERATION

### 7.1 Quality & Safety Team: Plan on a Page 2017/18

SF requested that any comments relating to items 7.1 – 7.3 be relayed through to Steven Forsyth directly. All comments were welcomed within 7 days of the meeting

### 7.2 Annual Quality and Risk Report 2016/17

As noted in 7.1.

### 7.3 Quality Strategy

As noted in 7.1.



## **8. POLICIES FOR CONSIDERATION**

### **8.1 Policy for the Notification of Serious Incidents in Commissioned Services**

The policy was submitted following a minor amendment. This was for information to the QSC

## **9. FEEDBACK FROM ASSOCIATED FORUMS**

### **9.1 Draft CCG Governing Body Minutes**

The minutes were noted by the committee.

### **9.2 Health & Wellbeing Board Minutes**

The minutes were noted by the committee.

### **9.3 Quality Surveillance Group**

The minutes were noted by the committee.

### **9.4 Primary Care Operational Management Group**

The minutes were noted by the committee.

### **9.5 Draft Commissioning Committee Minutes**

The minutes were noted by the committee.

### **9.6 Pressure Injury Steering Group.**

No minutes were available for the meeting.

## **10. ITEMS FOR ESCALATION/FEEDBACK TO CCG GOVERNING BODY**

No items were raised by the committee.

## **11. ANY OTHER BUSINESS**

SF wished to welcome Phil Strickland to the Quality team in a secondment role as a Quality Assurance Co-ordinator.

## **12. DATE AND TIME OF NEXT MEETING**

- ***Tuesday 13<sup>th</sup> June 2017, 10.30am – 12.30pm; CCG Main Meeting Room.***



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**WOLVERHAMPTON CLINICAL COMMISSIONING  
GROUP COMMISSIONING COMMITTEE**

Minutes of the Commissioning Committee Meeting held on Thursday 25<sup>th</sup> May 2017 commencing at 1.00 pm in the Main CCG Meeting Room, Wolverhampton Science Park

**MEMBERS ~**

**Clinical ~**

**Present**

Dr J Morgans	Chair	No
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**Patient Representatives ~**

Malcolm Reynolds	Patient Representative	Yes
Cyril Randles	Patient Representative	No

**Management ~**

Steven Marshall	Director of Strategy & Transformation (Chair)	Yes
Claire Skidmore	Chief Financial Officer	No
Manjeet Garcha	Executive Director Nursing & Quality	No
Juliet Grainger	Public Health Commissioning Manager	Yes
Paul Smith	Interim Head of Commissioning - WCC	No

**In Attendance ~**

Vic Middlemiss	Head of Contracting & Procurement	Yes
Helen Pidoux	Administrative Officer	Yes

**Apologies for absence ~**

Apologies were submitted on behalf of Julian Morgans, Manjeet Garcha, Claire Skidmore, and Cyril Randles. The meeting was Chaired by Steven Marshall

It was noted that as the meeting was not quorate decisions could not be made and reports were received for information only.

**Declarations of Interest**

CCM586 None.

RESOLVED: That the above is noted.

**Minutes**

CCM587 The minutes of the last Committee, which took place on Thursday 27<sup>th</sup> April 2017 were agreed as a true and accurate record to be approved at the next meeting

when quorate. An amendment to be made to the Nuffield resolution, item CCM 582, to read –

‘The above was noted and Dr Morgans confirmed that any change in the recommendations for hip and knee surgery overall must agree with our local NHS parameters’.

RESOLVED: That the above is noted and minutes to be approved at the next meeting when quorate.

### **Matters Arising**

CCM588 None discussed.

RESOLVED: That the above is noted.

### **Committee Action Points**

CCM589 (CCM582) Contracting and Procurement Update

- Urgent Care Centre – a quality update was included in the report on the agenda – action closed
- Dermatology – shortfall of consultants – an update was given that RWT have now recruited an additional 1.5 locums in addition to the locum already in place.

Communication has not yet been sent to GPs as further discussion to agree sub-contracting arrangements are required. Following confirmation of these arrangements a communication will be shared with Dr Morgans prior to circulation to the GPs.

Clarification to be sought from Head of Strategy & Transformation that the CCG is happy with the functionality of the Community Service.

RESOLVED: That the above is noted. Mr Marshall to respond to query relating to the functionality of the Community Dermatology service at the next meeting

### **Review of Risks**

CCM590 It was reported that the Risk Report for risks assigned to the Commissioning Committee is not yet available. The risks are currently being identified strategically and those relevant to the Commissioning Committee will be brought to the meeting once the ratification process is complete.

RESOLVED: That the above is noted.

## Contract & Procurement Report

CCM591 Mr Middlemiss presented the Committee with an overview and update of key contractual issues in relation to Month 12 (March 2017) for activity and finance.

### ***Royal Wolverhampton NHS Trust***

Sustainability and Transformation Fund (STF) indicators – The Trust has agreed trajectories for 2017/18 with NHS Improvement (NHSI) for A&E and RTT targets. Agreement is awaited on the Cancer 62 day target.

MRI/CT and Plain film X Rays – A concern has been raised with the Trust with regards to the backlog of unreported scans. The provider has assured the CCG that there are no concerns as a result of these delays. The Trust reports that the backlog is on track to be cleared by July 2017. This remains on the agenda of the Clinical Quality Review and Contract Review meetings.

Exception Reporting Proposal – The provider has confirmed that they will start populating exception reports in Quarter 1 (June 17). The final details are yet to be finalised and the agreed revision varied into the contract. This will provide increased assurance for the CCG of the level of performance.

Performance Sanctions – Total fines for Month 12 - £55,450.

Business Cases for fines/MRET/readmissions – A revised submission has been accepted by the CCG and a letter is to be sent to the Trust confirming this. The letter will also outline a more proactive process for 2017/18 which will encourage the Trust to submit business cases throughout the year. Clarification will also be given to what is the responsibility of the A&E Delivery Board versus what will be directed through the normal contracting route.

### ***Black Country Partnership Foundation Trust***

Fines / Sanctions – Sanctions applied, year to date, remain at £5,000. This relates to a safeguarding breach in Month 10. There were no further sanctions in Month 12.

Quality – A response has been received from the Trust in respect of the letter sent by the CCG raising concerns about the Trusts application of the Care Programme Approach for all patients following two patient deaths. Internal CCG feedback is awaited regarding the assurance taken from this response.

### ***Nuffield***

No significant concerns were raised;

Consideration was given to the discussions at the Contract Review meeting relating to the Business Cases increasing BMI rates.

RESOLVED: The above was noted and clarification was to be sought relating to the Business Cases for BMI rate increases.

## **Other contracts**

### **Urgent Care Centre**

Mr Middlemiss reported that following the concerns raised; as discussed at the last meeting, a time limited Improvement Board has been established. The Board will be chaired by the CCG's Executive Nurse of Quality and Risk. An extensive action plan has been developed and incorporates issues raised by the CCG and CQC. It was noted that the Quality and Safety Committee will have an overview of the quality issues and more detailed discussions will be held there.

RESOLVED: It was to be considered if the minutes of the Improvement Board should be circulated to the members of the Commissioning Committee.

### **WMAS- Non-Emergency Patient Transport (NEPT)**

Concerns have been raised with the provider regarding performance and the CCG has advised WMAS that the receipt of Quarter 1 data (April to June 17) will be awaited before a decision is made on raising a Contract Performance Notice.

### **Procurement Update**

Mr Middlemiss highlighted that the schedule has been updated and the procurement completed last year removed. The schedule shows procurements underway and those due to commence. This will continue to be updated.

Procurement Policy Proposal 2017/18 – The Committee reviewed an updated proposal which included information pertaining to the new procurement regulations. The major change highlighted was to the GP List based Services. It was felt that there was a need to review the wording relating to this and advice was to be sought from Mills and Reeve, the CCG's legal advisors.

The proposal could not be signed off as the meeting was not quorate. Any questions were to be raised with Mr Middlemiss and the report brought back to the next meeting.

RESOLVED: The Committee considered the proposal and asked that legal clarification be gained regarding the wording around the GP List Based Services. The Proposal to be brought to the next Commissioning Committee for ratification as this meeting was not quorate.

## **Any Other Business**

CCM592 There were no items raised.

## **Date, Time and Venue of Next Meeting**

CCM585 Thursday 22nd June 2017 at 1pm in the CCG Main Meeting Room



## WOLVERHAMPTON CLINICAL COMMISSIONING GROUP COMMISSIONING COMMITTEE

Minutes of the Commissioning Committee Meeting held on Thursday 25<sup>th</sup> May 2017  
commencing at 1.00 pm in the Main CCG Meeting Room, Wolverhampton Science Park

### MEMBERS ~

#### Clinical ~

**Present**

Dr J Morgans	Chair	No
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#### Patient Representatives ~

Malcolm Reynolds	Patient Representative	Yes
Cyril Randles	Patient Representative	No

#### Management ~

Steven Marshall	Director of Strategy & Transformation	Yes
Claire Skidmore	Chief Financial Officer	No
Manjeet Garcha	Executive Director Nursing & Quality	No
Juliet Grainger	Public Health Commissioning Manager	Yes
Paul Smith	Interim Head of Commissioning - WCC	No

#### In Attendance ~

Vic Middlemiss	Head of Contracting & Procurement	Yes
Helen Pidoux	Administrative Officer	Yes

#### Apologies for absence ~

Apologies were submitted on behalf of Julian Morgans, Manjeet Garcha, Claire Skidmore, and Cyril Randles.

It was noted that as the meeting was not quorate decisions could not be made and reports were received for information only.

#### Declarations of Interest

CCM586     None.

RESOLVED:     That the above is noted.

#### Minutes

CCM587     The minutes of the last Committee, which took place on Thursday 27<sup>th</sup> April 2017

were agreed as a true and accurate record to be approved at the next meeting when quorate. An amendment to be made to the Nuffield resolution, item CCM 582, to read –

The above was noted and Dr Morgans confirmed that any change in the recommendations for hip and knee surgery overall must agree with our local NHS parameters.

RESOLVED: That the above is noted and minutes to be approved at the next meeting when quorate.

### **Matters Arising**

CCM588 None discussed.

RESOLVED: That the above is noted.

### **Committee Action Points**

CCM589 (CCM582) Contracting and Procurement Update  
Urgent Care Centre – a quality update was included in the report on the agenda – action closed  
Dermatology – shortfall of consultants – an update was given that RWT have now recruited an additional 1.5 locums in addition to the locum already in place.

Communication has not yet sent to GPS as an executive meeting is due to be held with Walsall to discuss sub-contracting arrangements. Following confirmation of arrangements communications will be sent to GPs and will be shared with Dr Morgans prior to circulation.

Clarification to be sought from Head of Strategy & Transformation that the CCG is happy with the functionality of the Community Service.

RESOLVED: That the above is noted. Mr Marshall to respond to query re the Community Dermatology service at the next meeting

### **Review of Risks**

CCM590 It was reported that the Risk Report for risks assigned to Commissioning Committee is not yet available. The risks are currently being identified strategically and those relevant to the Commissioning Committee will be brought to the meeting when the ratification process is complete.

RESOLVED: That the above is noted.

## Contract & Procurement Report

CCM591 Mr Middlemiss presented the Committee with an overview and update of key contractual issues in relation to Month 12 (March 2017) for activity and finance.

### ***Royal Wolverhampton NHS Trust***

Sustainability and Transformation Fund (STF) indicators – The Trust has agreed trajectories for 2017/18 with NHS Improvement (NHSI) for A&E and RTT. Agreement is awaited on the Cancer 62 day target.

MRI/CT and Plain film X Rays – A concern has been raised with the Trust with regards to the backlog of unreported scans. The provider has assured the CCG that there are no concerns as a result of these delays. The Trust report that the backlog is on track to be cleared by July 2017. This remains on the agenda of the Clinical Quality Review and Contract Review meetings.

Exception Reporting Proposal – The provider has confirmed that they will start populating exception reports in Month 1 (June 17). The final details are net to be finalised and the agreed revision varied into the contract. This will increase the assurance for the CCG of the level of performance.

Exception Reporting Proposal – An exception reporting proposal has been discussed with the Trust who has advised that they will start populating reports from June 2017.

Performance Sanctions – Total fines for Month 12 - £55,450.

Business Cases for fines/MRET/readmissions – A revised submission has been accepted by the CCG and a letter is to be sent to the Trust confirming this. The letter will also outline a more proactive process for 2017/18 which will encourage the Trust to submit business cases throughout the year. Clarification will also be given to what is the responsibility of the A&E Delivery Board versus what will be directed through the normal contracting route.

### ***Black Country Partnership Foundation Trust***

Fines / Sanctions – Sanctions applied, year to date, remain at £5,000. This relates to a safeguarding breach in Month 10. There were no further sanctions in Month 12.

Quality – A response has been received from the Trust in respect of the letter sent by the CCG raising concerns about the Trusts application of the Care Programme Approach for all patients following two patient deaths. Internal CCG feedback is awaited regarding the assurance taken from this response.

### ***Nuffield***

No significant concerns were raised; however the following paragraph in the report was discussed;

‘The Business Case for increasing the BMI rate from 35 to 39 was discussed at the last Contract Review Meeting. Consultants that work for the hospital have advised

that the BMI rate only applies to hip/ knee procedures. They have said that when they work at RWT they still accept patients with a BMI over 35 they just don't carry out the hip/ knee replacement. Further discussion is ongoing.

RESOLVED: The above was noted and clarification was to be sought.

### ***Other contracts***

#### ***Urgent Care Centre***

Mr Middlemiss reported that following the concerns raised as discussed at the last meeting a time limited Improvement Board has been established. The Board will be chaired by the Executive Nurse of Quality and Risk. An extensive action plan has been developed and incorporates issues raised by the CCG and CQC. It was noted that the Quality and Safety Committee will have an overview of the quality issues and more details discussions will be held there.

RESOLVED: It was to be considered if the minutes of the Improvement Board should be circulated to the members of the Commissioning Committee.

#### ***WMAS- Non-Emergency Patient Transport (NEPT)***

Concerns have been raised with the provider re performance and the CCG has advised WMAS that the receipt of Quarter 1 data (April to June 17) is awaited before a decision is made on raising a Contract Performance Notice.

#### ***Procurement Update***

Mr Middlemiss highlighted that he schedule has been updates and the procurement completed last year removed. The schedule shows procurements underway and those due to commence. This will continue to be updated.

Procurement Policy Proposal 2017/18 – The Committee reviewed an updated proposes which included information pertaining to the new procurement regulations. The major change highlighted was to the GP List based Services. It was felt that there was new to review the wording relating to this and advice was to be sought from Mills and Reeve.

The proposal could not be signed off as the meeting was not

RESOLVED: The Committee considered the proposal and asked that legal clarification be gained regarding the wording. The Proposal to be brought to the next Commissioning Committee for approval as this meeting was not quorate.

### **Any Other Business**

CCM592 There were no items raised.

**Date, Time and Venue of Next Meeting**

CCM585 Thursday 22nd June 2017 at 1pm in the CCG Main Meeting Room

RESOLVED: That the above is noted.

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**WOLVERHAMPTON CLINICAL COMMISSIONING GROUP**

**Finance and Performance Committee**

**Minutes of the meeting held on 25<sup>th</sup> April 2017  
Science Park, Wolverhampton**

**Present:**

Mr P Price	Independent Committee Member (Chair)
Mrs C Skidmore	Chief Finance and Operating Officer
Mr S Marshall	Director of Strategy and Transformation(Part meeting)
Mr M Hastings	Associate Director of Operations
Dr D Bush	Governing Body GP, Finance and Performance Lead
Mr L Trigg	Independent Committee Member

**In regular attendance:**

Mr G Bahia	Business and Operations Manager
Mr V Middlemiss	Head of Contracting and Procurement
Mrs L Sawrey	Deputy Chief Finance Officer

**In attendance**

Mrs H Pidoux	Administrative Team Manager
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**1. Apologies**

Apologies were submitted by Mr Oatridge.

Mr Price welcomed Mr Trigg to the meeting and explained that he would be taking over as interim chair of the Committee from the May meeting

**2. Declarations of Interest**

FP.153 There were no declarations of interest.

**3. Minutes of the last meetings held on 28<sup>th</sup> March 2017**

FP.154 The minutes of the last meeting, public and private, were agreed as a correct record with the caveat that the following change was made to the public minutes;

- Item FP.148 Monthly Performance Report – the number of green rated indicators to be changed to 40 from 43.

#### **4. Resolution Log**

FP.155

- Item 100 (FP.16.127) – Consideration to be given to how the key areas of performance are reported to Governing Body - noted that the report reflects the Area Team monthly monitoring agenda. The Committee asked for the report to bring the Committee's attention to any discussion points to draw out where the Committee has some influence to resolve or if there is a need to escalate.
- Item 101 (FP.16.135) – Quality and Safety Committee minutes to be reviewed re level of discussion re Safeguarding training at RWT and decision required as to which Committee takes the lead for monitoring the uptake of Safeguarding training – this is to be taken to the Executive meeting to discuss with the Executive Director of Nursing and Quality – deferred until Executive Director returns from sick leave.
- Item 102 (FP.135) – The lack of information re Safeguarding Training for Board Level Staff at RWT to be checked to ensure that the training is being undertaken at that level – a section relating to Safeguarding Training report has been included in the Monthly Performance report – action closed
- Item 104 (FP.148) – Brief report to April meeting outlining on-going work around Demand Management and Referral Management - plan brought to the meeting and discussed under item FP.158 monthly performance report – action closed
- Item 105 (FP.150) – Draft Annual Report – any comments to be forwarded to Peter McKenzie, Corporate Operations Manager – on agenda – action closed.

#### **5. Matters Arising from the minutes of the meeting held on 28<sup>th</sup> March 2017**

FP.156 There were no matters arising from the previous minutes.

#### **6. Finance Report**

FP.157

Mrs Sawrey reported that the Year End Accounts had been closed and no queries had been received from NHS England (NHSE) at the time of the meeting. All financial metrics were achieved and QIPP delivery was 95% of the target. This was the highest level of QIPP achieved by the CCG.

A surplus of £10.43m has been delivered which is £0.883m over target (£6.172) plus £3.375 being the release of the 1% reserve to the bottom line (as nationally mandated)

Mrs Sawrey stated that there were no major movement to report with the exception of the Better Care Fund. She noted that it is disappointing that there are still issues with Local Authority accounting methodology and systems. Assurance was taken previously that, following processes put in place after similar issues last year, problems had been addressed. It would appear that this is not the case.



It was confirmed that there are no sanctions the CCG can use if the outturn worsens. Any additional overspend included in City of Wolverhampton Council's impact on the CCG's finances in 2017/18. An audit of the whole Pooled Budget Agreement could be considered if necessary. Mrs Skidmore confirmed that the Better Care Fund is included in the Internal Audit programme for 2017/18, the details are to be finalised.

Mr Price queried if there are any areas of significant overspend which the CCG does not have flexibility to cover that can be drawn out. It was agreed to review and revisit risk profiling at the next meeting.

Mr Price commended the CCG on its achievement and recognised the hard work of the Finance Team and Budget Holders in doing this.

Resolved: The Committee

- Noted the content of the report
- Requested that a report on risk and mitigation is brought to the next meeting.

Mr Marshall left the meeting

## **7. Monthly Performance Report**

FP.158 Mr Bahia highlighted that of the indicators for Month 11, 40 are green rated, 29 are red rated, 23 have no submissions and 2 is awaiting target.

Mr Bahia stated that work is being undertaken to improve reporting particular around measures where there are no submissions or targets are missing. This will be embedded in 2017/18 reporting.

The following key points from the report were discussed;

- Safeguarding – a dashboard giving an overview of safeguarding training (children and adults) performance against target. A number of issues had been highlighted during the CCG's interrogation of the data following the request from the Committee. Going forward discussions are taking place in relation to the indicators and how to report the information which will mean the reporting is more reliable and will flag any concerns.

A query was raised in relation to the 100% achievement of Board level staff attending training and it was asked that this should be ratified.

It was confirmed that if targets are continually not met there are specific financial sanctions in the main contract linked to quality requirement that can be implemented.

- RTT - continues to perform marginally below threshold mainly due to capacity and demand issues. 4 Dermatology staff left at the same time which had impacted on performance. The provider is reporting that performance can be recovered by the end of Quarter 1. Performance in March has increased to 91%,
- Diagnostics – Continues to perform marginally below target due to two areas CT and MRI scans. The sole cardiac consultant left for maternity leave and the locum consultant brought in to cover cannot maintain workload level of substantive staff. The Trust has tried additional recruitment but this has been unsuccessful. A change in NICE guidelines in November 2016 has also increased the number of referrals.
- A&E – A RAP is in place and a small improvement has been seen. CCG are discussing activity levels with Vocare. Delays with first assessments are primarily due to over reliance on locums. The Trust is discussing a revised trajectory with NHSI.
- 62 day cancer waits – historically performance has been below target. Breaches have occurred in 5 areas, Urology, Colorectal, Head and Neck, Upper GI and Gynaecology. Saturday clinics were planned throughout April; however these will see patients who have already breached. The outcome of the Trusts discussions with NHSI regarding a recovery trajectory is awaited.

It was noted that NHSE and NHSI have different trajectories for meeting targets. These need to be clear when the CCG is developing RAPs.

- Zero tolerance RTT waits over 52 weeks wait for incomplete pathways – Performance is currently ahead of the recovery trajectory (all orthodontic patients). The Trust has provided an updated Remedial Action Plan for the Orthodontic breaches with a recovery trajectory confirming zero breaches by June 2017.
- Delayed Transfer of Care – issues are predominately delays awaiting assessments, further care or domiciliary packages. There are a higher number of Staffordshire delays, accounting for 25% of all delays. In line with the national view a reducing trajectory has been set for next year to be achieved by Q4.
- Handover breaches – a high number of breaches occurred in February, however, there has been a significant reduction in the number of breaches in March.
- Discharge Summary – it has been identified that the issues are people related as there are no problems with the system and further training is to be arranged to improve this.

Mr Bahia reported that provisional data has been received from RWT for the majority of performance indicators for Month 12. Although the figures are subject to change they give an indication of the final performance position for the year. It was noted that this information was as expected.

Mr Price asked if it would be possible to identify where reports have made a difference so that this can be shared with the Governing Body.

Referral and Demand Management – Mr Hastings gave an overview of the work being carried out to address the issues relating to referral to treat to improve performance in this area. A summary of the agreed actions have been shared with NHSE.

Members were asked to review the 'live' document shared at the meeting and to consider areas of focus and any comments to be shared with Mr Hastings.

It was agreed that an updated report should be brought back on a quarterly basis.

Resolved:

- The Committee noted the content of the report
- 100% achievement of Board level staff attending safeguarding training to be ratified
- Consider where reports have influenced performance and sharing with Governing Body
- Referral and Demand Management document to be reviewed and comments forwarded to Mike Hastings
- Updated Referral and Demand Management report to be brought back to the Committee on a quarterly basis.

## **8. Monthly Contract and Procurement Report**

FP.159 Mr Middlemiss presented this report based on Month 11 information and highlighted the following key points;

Royal WolverhamptonTrust (RWT) -

- Exception Reporting Proposal –the new mechanism proposed by the CCG has been agreed in principle by the Trust. The Provider has advised that they will start populating exception reports in June 2017.

In addition, the Trust has agreed in principle to take over presenting the contract performance finance and activity data, working to the same timeframe so that it commences Month 1 data. The CCG in conjunction with the CSU will still undertake the same level of analysis it has been doing which includes benchmarking with other acute providers. This will ensure the

CCG is prepared with questions to take into the CRMs and to raise queries if the RWT data fails to provide the required level of assurance for activity lines off trajectory.

Mr Middlemiss reported that further work is on-going to embed the new query log process, an internal forum for the CCG to review responses from the Trust.

- Sanctions – it was noted that the total fines value for Month 11 is £78,700.
- Business cases for fines/MRET/readmissions – Business cases for MRET, re-admissions and sanctions have been received and accepted with a caveat that this is with the expectation that they will be clearer for 2017/18. The CCG will require the Trust to be more proactive with submissions.

It was agreed that a draft proposal setting out the CCG's expectations should be brought to the next meeting.

- Dermatology – the Trust is experiencing major challenges in this speciality due to a shortfall in Dermatology consultants. The CCG is holding discussions with local providers regarding capacity and capability to take on some of the work. The Trust has been asked to provide a breakdown of referrals by GP and condition. A meeting was due to be held with RWT to discuss options, plans and future provision of the service.

#### Black Country Partnership Foundation Trust (BCPFT) –

- Routine EIS referrals within 10 days – The target for routine EIS referrals within 10 days achieved 100% in February. However a RAP has been issued to the Trust as this indicator is often breached due to patient 'did not attends'. Actions have been set to address this issue and to review the Trust DNA and Access Policy as part of the RAP.
- Data Quality Improvement Plan (DQIP) – Following a meeting with BCPFT and other Commissioners actions have been agreed to address data submission concerns in the following areas, Early Intervention Psychosis, CAMHS, Eating Disorders, IAPT, Dementia and Out of Area Placements.

## Nuffield

- Contract issues - Nuffield Health have submitted a Business Plan wanting to increase the BMI rate from 35 to 39 for all patients. This is because they believe Wolverhampton to be an outlier compared to other Nuffield Hospitals within the group, whereby those other hospitals see patients with a BMI cut off of 39. The CCG's Head of Quality and Risk has asked for advice in regards to the clinical benefit of this and how the additional risk for patients with a higher BMI will be managed. Further information is awaited.
- A suggestion contained in the report that Nuffield submit data on day 20 rather than day 10 to ensure accuracy was questioned as the SLAM data is required earlier than day 20 for finance forecasting purposes. It was agreed to discuss this outside the meeting.

## Other Contracts/Significant Contract Issues

### Urgent Care Centre (UCC) –

- As Vocare are failing to deliver the quality standards set out in the contract and quality issues raised following CQC inspection, the CCG is working closely with CQC to address the issues. This is being managed via the monthly Contract and Quality Review meetings held with Vocare and a recently established Improvement Board which includes a CQC representative. An urgent response and action plan has been requested from Vocare.

As a result of the significant underperformance in the 16/17 contract, the CCG have written to the Provider advising of the year end claw back, as supported by the F&P Committee in February. Upon receipt of M12 data, the year-end underspend has been updated to £204k and an invoice has been issued accordingly. Vocare have replied asking the CCG to consider lowering the activity plan for 2016/17. Further discussion will be held, however, the view of the Committee was that the Provider would need to evidence this.

### WMAS Non-emergency Patient Transport

- Performance has been deteriorating and the Provider has advised that this is due to an unusual set of circumstances, including a high level of annual leave at year end which had been agreed by the previous Provider. The CCG remains concerned and has reiterated to the Provider that this is not acceptable on an on-going basis. The Provider is working to reduce the decline in performance.

Resolved – The Committee:

- noted the contents of the report and actions being taken.
- A draft proposal setting out the CCG's expectation for MRET/readmissions/fines business cases should be brought to the next meeting.

## **9. Draft Annual Report**

FP.160 Mr Price stated that Mr McKenzie, Corporate Operations Manger had confirmed that minor changes as requested had been made to the Annual Report which was shared at the last meeting. A conclusion will be shared with Mr Price before it goes to the Governing Body meeting at the end of May.

The Committee;

- Noted that the Annual Report had been completed and a conclusion will be shared with Mr Price before it is taken to Governing Body.
- Noted that the Committee has discharged it's duties as set out in its terms of reference.

## **10. Any Other Business**

FP.161 Mr Trigg raised a point relating to the use of acronyms. He requested that either a glossary of terms is included in reports or that they written out in full on the first instance of being included in a report.

## **11. Date and time of next meeting**

FP.162 Tuesday 30<sup>th</sup> May 2017 at 2.30pm, CCG Main Meeting Room

**Signed:**

**Dated:**

**WOLVERHAMPTON CLINICAL COMMISSIONING GROUP**

**Finance and Performance Committee**

**Minutes of the meeting held on 30<sup>th</sup> May 2017  
Science Park, Wolverhampton**

**Present:**

Mr L Trigg	Independent Committee Member (Chair)
Mrs C Skidmore	Chief Finance and Operating Officer
Mr S Marshall	Director of Strategy and Transformation
Mr J Oatridge	Chair of the CCG
Dr D Bush	Governing Body GP, Finance and Performance Lead

**In regular attendance:**

Mr G Bahia	Business and Operations Manager
Mr V Middlemiss	Head of Contracting and Procurement
Mrs L Sawrey	Deputy Chief Finance Officer

**In attendance**

Mr T Gallagher	Chief Finance Officer, Walsall CCG
Mr M Hartland	Chief Finance Officer, Dudley CCG
Mrs H Pidoux	Administrative Team Manager

**1. Apologies**

Apologies were submitted by Mr Hastings

Mr Trigg welcomed Mr Gallagher and Mr Hartland to the meeting. It was confirmed that as from 1<sup>st</sup> June 2017, due to Mrs Skidmore leaving her role, Mr Gallagher will be the Chief Finance Officer for Wolverhampton CCG for 2.5 days a week and Mr Hartland will be providing strategic finance support to the CCG.

**2. Declarations of Interest**

FP.163 There were no declarations of interest.

**3. Minutes of the last meetings held on 25<sup>th</sup> April 2017**

FP.164 The minutes of the last meeting were agreed as a correct record.

#### **4. Resolution Log**

FP.165

- Item 100 (FP.16.127) – Consideration to be given to how the key areas of performance are reported to Governing Body – it was noted that the packs are currently under development for 2017/18 reporting and any feedback from Mr Trigg as the Chair or any members would be appreciated. – Action closed.
- Item 101 (FP.16.135) – Quality and Safety Committee minutes to be reviewed re level of discussion re Safeguarding training at RWT and decision required as to which Committee takes the lead for monitoring the uptake of Safeguarding training – due to sick leave and the subsequent annual leave of the Executive Director for Nursing and Risk, this would be followed up with her by Mr Hastings going forward.
- Item 106 (FP.157) – Risk and mitigation 17/18 information – on private agenda – action closed
- Item 107 (FP.158) – 100% achievement of Board level staff attending safeguarding training to be ratified – this has been raised with RWT and awaiting a response which will include May data. Deferred to the next meeting.
- Item 108 (FP.158) – Referral and Demand Management documents to be reviewed and comments feedback to Mr Hastings – completed – action closed.
- Item 109 (FP.159) – A draft proposal setting out the CCG's expectation for MRET/readmissions/fines business cases to be brought to the next meeting – included in Contract and Procurement Report on agenda – action closed.

#### **5. Matters Arising from the minutes of the meeting held on 25<sup>th</sup> April 2017**

FP.166 There were no matters arising from the previous minutes.

#### **6. Finance Report**

FP.167

Mrs Sawrey confirmed that the accounts had been submitted to NHS England (NHSE) that day. The CCG reported a £75k surplus comprising of £3k overspend in programme costs and £78k underspend in Running Costs.

It was noted that the escalation of the £4.8m invoice issued by RWT is yet to be resolved. The CCG is awaiting feedback on this.

Resolved: The Committee noted;

- That the final accounts have been submitted and the details of the surplus reported
- The current situation regarding the RWT invoice.



## 7. Monthly Performance Report

FP.168 Mr Bahia highlighted that of the indicators for Month 12, 46 are green rated, 28 are red rated, 18 have no submissions and 2 are awaiting target.

The following key points from the report were discussed;

- RTT - continues to perform marginally below threshold mainly due to capacity and demand issues. Demand management work is continuing. The Trust has highlighted the end of June 17 for recovery.

Mr Marshall raised that assurance had been given by the Trust that the Dermatology performance would not be compromised as staffing levels were being managed and were using local providers. It was felt that the direct impact of these issues on RTT performance should be reviewed when April data is available.

- Diagnostics – Continues to perform marginally below target due to two areas CT and MRI scans. RWT are recruiting additional staff and are reporting expected recovery by the end of June 17.
- A&E – an improvement in performance has been seen. It was noted that a graphical representation of performance was included in the report, however, due to variances it is difficult to show a 'like for like' comparison.
- 62 day cancer waits – historically performance has been below target. Key areas of concern are capacity in speciality areas including Urology, which is a national issue, and late tertiary referrals. A second recovery trajectory has been submitted by RWT to NHSI and the outcome of this is awaited.
- Zero tolerance RTT waits over 52 weeks wait for incomplete pathways – Performance is currently ahead of the recovery trajectory (all orthodontic patients). The Trust's Remedial Action Plan for the Orthodontic breaches has a recovery trajectory confirming zero breaches by June 2017.
- Delayed Transfer of Care – health related transfers are below the 2.5 % threshold and on target, however, social care delays are impacting significantly on combined performance. This is being monitored through the A&E Delivery Board.
- Percentage of all routine EIS referrals, receive initial assessment within 10 working days – the March data refers to 13 clients in total, of which 1 client breached standard. It was noted that for such a small co-hort of patients, 1 breach has a significant impact on performance.
- Delayed Transfer of Care (Mental Health) – this has been an on-going issue throughout the year, however, since January there has been a significant improvement.
- C. Diff – there has been a reduction in breaches. A new programme of work at the Trust has brought the numbers down.
- Handover breaches –there has been a significant reduction in the number of breaches in March, however, there have been a

significant increase in breaches over the year which the Trust accredits mainly to the batching of ambulance arrivals.

Mr Bahia highlighted the following positives from the report;

- MRSA Bacteraemia– the target for this is nought and there have been no breaches all year
- Over 90% average performance for A&E where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department
- Health related DTOCs are below threshold
- C Diff – significant improvement in the number of cases seen
- Mental Health IAPT's – all national measures have been achieved.

Resolved: The Committee noted the content of the report

## **8. Monthly Contract and Procurement Report**

FP.169 Mr Middlemiss presented this report based on Month 12 information and highlighted the following key points;

Royal Wolverhampton Trust (RWT) -

- Sustainability and Transformation Fund (STF) indicators  
RWT have confirmed that the trajectories for A&E, compliant by July 2017 (92%) and RTT, to be compliant by July 2017 (92%) have been agreed by NHSI. The trajectory for Cancer 62 day waits is still to be agreed.

Once the trajectories are agreed these will be part of the Remedial Action Plans for these areas if they apply to ensure uniform trajectories are being used.

- MRI/CT and Plain film X-rays  
The Trust is outsourcing to an external company to reduce the backlog of unreported scans. The majority of these are related to internal referrals. RWT are reporting that the backlog will be cleared by July 2017 and is currently on trajectory to achieve this.

The Committee asked for assurance as to how the Trust is planning to prevent a backlog reoccurring as there is a high level of scans being undertaken. It was noted that the Trust had not reported the backlog, it was discovered due to a Serious Incident Report. Due to this it is now reported through the Clinical Quality Review meeting. The Committee also asked for information on who the work is

being outsourced to and the contractual agreement in place.

- Exception Reporting Proposal – the new mechanism proposed by the CCG has been agreed in principle by the Trust. The Provider has advised that they will start populating exception reports in June 2017. The Trust has expressed concerns around some areas of the proposal and a meeting is planned to discuss these.

In addition, the Trust has agreed in principle to take over presenting the contract performance finance and activity data, working to the same timeframe so that it commences Month 1 data. The CCG in conjunction with the CSU will still undertake the same level of analysis it has been doing which includes benchmarking with other acute providers. This will ensure the CCG is prepared with questions to take into the CRMs and to raise queries if the RWT data fails to provide the required level of assurance for activity lines that are deemed to be 'off trajectory'. RAPs will be applied where necessary. It is felt that the benefits will be seen once the process is embedded.

- Service Development Improve Plan (SDIP)  
This key document remains unsigned. As part of the contract negotiation round it was agreed that this would be agreed in Quarter 4 and varied into the contract by the commencement date (1<sup>st</sup> April 2017). This is being flagged as a risk. Some elements of the plan have required escalation to director level. The Plan has been revised to reflect director agreements and reformatted to distinguish between those schemes requiring RWT input from those which do not. This version is now with the Trust for agreement and to be finalised by the end of May.
- Sanctions – it was noted that the total fines value for Month 12 is £55,450.

Business cases for fines/MRET/readmissions – as requested at the last Committee meeting a draft proposal setting out the CCG's expectations for the 2017/18 financial year was included in the report. The proposal set out in the report was considered by the Committee.

In relation to point 10, the Committee agreed that the recommendation for approval/rejection by the internal business case forum should be made to the Commissioning Committee and subsequently the Governing Body.

Following discussion the Committee approved the proposal

- Dermatology – following the major challenges experience by the Trust in this speciality due to a shortfall in Dermatology consultants, two further locums have been recruited and additional support obtained from an external provider.

#### Black Country Partnership Foundation Trust (BCPFT) –

- Data Quality Improvement Plan (DQIP)  
A way forward has been agreed and is due for sign off.
- Service Development Improve Plan (SDIP)  
A final version is being shared with the Trust for sign off. This will then be monitored through the contract review meeting.

#### Other Contracts/Significant Contract Issues

##### WMAS Non-emergency Patient Transport

- Performance has shown a deteriorating position month on month. WMAS has been advised that the CCG will await the receipt of Quarter 1 data (April to June 17), before making a decision to raise a Contract Performance Notice (CPN). Areas of concern have been highlighted.

##### Urgent Care Centre (UCC) –

- An Improvement Board has now been established and an extensive action plan has been drawn up by Vocare. A Step-In Team has been established by Vocare to provide support to the local team. An invoice to the value of £204k has been raised in reference to the activity underperformance between April 16 and March 17. The CCG has offered the Provider an opportunity for Vocare to claim some of the funds back via an incentive based offer, to a total sum of £80k. Robust proposals are required to improve triage and out of hours service. An exit plan will also be required as this money is non-recurrent.

#### Resolved – The Committee:

- noted the contents of the report and actions being taken.
- approved the draft proposal setting out the CCG's expectation for MRET/readmissions/fines business cases.

## 10. Any Other Business

FP.170 The Committee thanked Mrs Skidmore for her contribution in her role as Chief Finance and Operating Officer and recognised the immense amount of work she had done during her time working in Wolverhampton for both the PCT and CCG. Best wishes were given to Mrs Skidmore for her new role.

**11. Date and time of next meeting**

FP.171 Tuesday 27<sup>th</sup> June 2017 at 3.15pm, CCG Main Meeting Room

**Signed:**

**Dated:**

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**WOLVERHAMPTON CLINICAL COMMISSIONING GROUP  
PRIMARY CARE COMMISSIONING COMMITTEE**

Minutes of the Primary Care Commissioning Committee Meeting (Public)  
Held on Tuesday 4<sup>th</sup> April 2017, Commencing at 2.00 pm in the in the Marston Room, Ground  
Floor, Technology Centre, Wolverhampton Science Park

**MEMBERS ~  
Wolverhampton CCG ~**

		Present
Pat Roberts	Chair	Yes
Dr David Bush	Governing Body Member / GP	Yes
Dr Manjit Kainth	Locality Chair / GP	No
Dr Salma Reehana	Locality Chair / GP	Yes
Steven Marshall	Director of Strategy & Transformation	No
Manjeet Garcha	Executive Lead Nurse	No
Peter Price	Lay Member (Vice Chair)	Yes

**NHS England ~**

Bal Dhami	Contract Manager	Yes
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**Independent Patient Representatives ~**

Jenny Spencer	Independent Patient Representative	No
Sarah Gaytten	Independent Patient Representative	Yes

**Non-Voting Observers ~**

Ros Jervis	Service Director Public Health and Wellbeing	Yes
Elizabeth Learoyd	Chair - Wolverhampton Healthwatch	No
Dr Gurmit Mahay	Vice Chair – Wolverhampton LMC	No
Jeff Blankley	Chair - Wolverhampton LPC	Yes

**In attendance ~**

Mike Hastings	Associate Director of Operations (WCCG)	Yes
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Jane Worton	Primary Care Liaison Manager (WCCG)	Yes
Claire Skidmore	Chief Finance and Operating Officer (WCCG)	Yes
Helen Hibbs	Chief Accountable Officer	No
Sarah Southall	Head of Primary Care	No
Matthew Boyce	Primary Care Development Manager	Yes
David Birch	Head of Medicines Optimisation	Yes
Laura Russell	Primary Care PMO Administrator (WCCG)	Yes

## **Welcome and Introductions**

WPCC01 Ms Roberts welcomed attendees to the meeting and introductions took place.

## **Apologies for absence**

WPCC02 Apologies were submitted on behalf of Dr Helen Hibbs, Manjeet Garcha, Steven Marshall, Elizabeth Learoyd, Dr Kainth and Sarah Southall.

Ms Roberts noted that in Ms Garcha absence, Ms Skidmore is the nominated core Executive Representative and therefore the meeting would be quorate.

## **Declarations of Interest**

WPCC03 Dr Bush and Dr Reehana declared that, as GPs they had a standing interest in all items related to primary care.

Ms Gaytten declared that, in their role as employee 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 Primary Care Commissioning Committee Meeting Held on the 7<sup>th</sup> March 2007**

WPCC04 RESOLVED:

That the minutes of the previous Primary Care Commissioning Committee meeting held on 7<sup>th</sup> March 2017 were approved as an accurate record.

## **Matters arising from the minutes**

WPCC05 There were no matters arising from the minutes.

**RESOLVED: That the above is noted.**



## Committee Action Points

### WPCC06 **Minute Number PCC302 – Premises Charges (Rent Reimbursement)**

NHS England confirmed they are still awaiting the new cost directives and will inform the CCG once this has been received. This will help to provide clarity on rent reimbursement in relation to when Practices allow other service providers using their rooms such as midwives.

### **Minute Number PCC283 – Wolverhampton CCG Update**

It was confirmed that Ms Southall will provide a joint evaluation report on the two extended opening hours scheme at the May Meeting.

### **Minute Number PCC329 – Wolverhampton CCG Update**

Ms Cresswell to confirm the details regarding the specific areas where patients feel they are not being provided with patient choice at the May meeting.

### **Minute Number PCC333 – General Practice Forward View Implementation Plan**

Ms Jervis confirmed they have discussed within a number of different forums regarding the Primary Care programme of work and Public Health are sighted on these developments. Action closed.

It was highlighted the actions that have remained open from the Primary Care Joint Commissioning Committee will be carried forward onto the new Primary Care Commissioning Committee action log.

**RESOLVED: That the above is noted.**

## Medicines Optimisation QIPP 2017/2018

WPCC07 Mr Birch, Head of Medicines Optimisation presented to the Committee the Medicines Optimisation QIPP 2017/2018 report, which seeks approval for the amendments to the Quality Prescribing Scheme for 2017/2018. These changes include;

- An increase in the overall funds within the Quality Prescribing Scheme
- To commit additional funds to the Primary Care Medicines Team for additional respiratory medication reviews.

The GP Quality Incentive Scheme has been offered historically to support the QIPP agenda and it proposed to offer this service again. The current budget for 2016/17 is £250k and it is proposed to increase his amount to £450k to incentive an increase number of individual components within this year's scheme.

Mr Birch provided an overview of the potential payments which are found within the table on page 3 of the report and highlighted additional areas they would like to build upon QIPP savings includes the following, low cost blood glucose testing

strips, diabetic pen needles and branded buprenorphine patches. In addition to this there are opportunities with regards to respiratory to change the prescribing to have a more cost effective tiotropium inhaler. There will be a big change to the brand prescribing of inhalers and this would require an additional funding to invest in a specialist respiratory pharmacist to support this piece of work.

Mr Birch shared with the Committee the detailed work plan for 2017/2018 and the proposed service specification for 2017/2018. It was highlighted within the specification there is a requirement for Practices to use electronic tools available, switch script and eclipse live.

Dr Bush stated his concerns on how to keep the two pharmacists roles within the GP practices separate as they are funded separately. It was agreed that if these two roles are carried out by the same pharmacist then the roles need to be kept separate as the two roles provide different functions. It was queried whether the NHS England funding can be used to provide support to keep these roles separate. Mr Birch explained the National funding is around Clinical Pharmacist in GP Practices and available on a bid basis which Wolverhampton CCG have put forward number of bids and are awaiting an outcome.

Dr Reehana asked in relation to the baseline behind the reasoning for the percentage of oral morphine prescribing as a percentage of strong opioid prescribing has to be above 40%. Mr Birch stated the target of 40% has been set for Wolverhampton because in comparison to other CCGs they are low in prescribing morphine. This target will help prompt GPs whether to prescribe morphine as the NICE guideline state *if strong opioids are required, oral morphine should be the first choice for most patients and is a cost effective choice compared with other stronger opioids, such as fentanyl, buprenorphine and oxycodone, which are considerably more expensive.* Dr Reehana raised her concerns with prescribing oral morphine and from a clinical perspective the use of morphine patches can be monitored with the patient.

The Committee reviewed the report and enclosures and agreed to the following recommendations;

- Approve the revised incentive specification (Quality Prescribing Scheme Service Specification).
- Approve the increase in budget for the Quality Prescribing Scheme Service Specification
- Approve the additional investment in a specialist respiratory pharmacist
- Note the possible impact on the CCG Quality Premium.
- Request CCG contracting team to offer the revised contract to practices alongside other enhanced services.

**RESOLVED: That the above is noted.**

**Primary Care Commissioning Committee Terms of Reference**

WPCC08 Mr McKenzie presented the Primary Care Commissioning Committee Terms of Reference with the Committee for their information and approval. Mr McKenzie noted the CCGS Constitution has been agreed by NHS England and the terms of reference have been written in line with the National template. The Committee reviewed and formally approved the Terms of Reference for the Primary Care Commissioning Committee.

**RESOLVED: That the above is noted.**

### **Draft Minutes of the Primary Care Strategy Committee**

WPCC09 The draft minutes of the Primary Care Strategy Committee were shared with the Committee for information. The minutes provide an overview of the progress or work being undertaken against the Primary Care Strategy programme of work.

**RESOLVED: That the above is noted.**

### **Primary Care Operational Management Group Meeting**

WPCC10 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 20<sup>th</sup> March 2017. The following items were highlighted to the Committee;

- There has been an overall improvement within the infection prevention rates following Practices visits that have been undertaken within the month of January.
- There are seven Practices who did not submit Friends and Family data for the month of January. It was highlighted there had been issues with the CQRS not showing data as submitted although the Practices had submitted data and this issue is being investigated.
- The collaborative joint contract review pilot visits were completed at the end of March 2017. The programme for the next six months is currently being arranged.
- The practices online access programme continues which provides support to patients to sign up to patient online. There are different methods being introduced to support those Practices who are struggling to meet the 10% target.
- The Zero Tolerance Policy has come into effect and the new provider is anticipated to commence from the 1<sup>st</sup> May 2017.
- The CQC inspection programme for 2016/2017 has been completed.
- Matt Boyce has commenced his role as Primary Care Development Manager and will supporting the GP Forward View programme of work.

**RESOLVED: That the above is noted.**

## **Any Other Business**

WPCC11 There were no further discussion items raised by Committee.

**RESOLVED: That the above is noted.**

WPCC12 **Date, Time & Venue of Next Committee Meeting**  
Tuesday 2<sup>nd</sup> May 2017 at 2.00pm in the Stephenson Room, 1<sup>st</sup> Floor, Technology Centre, Wolverhampton Science Park

**WOLVERHAMPTON CLINICAL COMMISSIONING GROUP  
PRIMARY CARE COMMISSIONING COMMITTEE**

Minutes of the Primary Care Commissioning Committee Meeting (Public)  
Held on Tuesday 2<sup>th</sup> May 2017, Commencing at 2.00 pm in the in the Stephenson Room,  
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)	No

**NHS England ~**

Bal Dhami	Contract Manager	Yes
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**Independent Patient Representatives ~**

Jenny Spencer	Independent Patient Representative	No
Sarah Gaytten	Independent Patient Representative	Yes

**Non-Voting Observers ~**

Ros Jervis	Service Director Public Health and Wellbeing	Yes
Elizabeth Learoyd	Chair - 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**

WPCC23 Ms Roberts welcomed attendees to the meeting and introductions took place.

## **Apologies for absence**

WPCC24 Apologies were submitted on behalf of Alastair McIntyre, Jeff Blankley, Jenny Spencer, Manjeet Garcha and Les Trigg.

Ms Roberts informed the group Mr Trigg will be the new Lay Member and Vice Chair of the Primary Care Commissioning Committee.

Ms Roberts noted that in Ms Garcha absence, Ms Skidmore is the nominated core Executive Representative and therefore the meeting would be quorate.

## **Declarations of Interest**

WPCC25 Dr Kainth declared that, as GP he had a standing interest in all items related to primary care.

Ms Gaytten declared that, in her role as employee of the University of Wolverhampton, she 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 Primary Care Commissioning Committee Meeting Held on the 4<sup>th</sup> April 2017**

WPCC26 RESOLVED:

That the minutes of the previous Primary Care Commissioning Committee meeting held on 4<sup>th</sup> April 2017 were approved as an accurate record.

## **Matters arising from the minutes**

WPCC27 There were no matters arising from the minutes.

**RESOLVED: That the above is noted.**

## **Committee Action Points**

WPCC28 **Minute Number PCC302 – Premises Charges (Rent Reimbursement)**  
NHS England confirmed they are still awaiting the new cost directives and will inform the CCG once this has been received. This will help to provide clarity on rent reimbursement in relation to when Practices allow other service providers using their rooms such as midwives.

### **Minute Number PCC283 – Wolverhampton CCG Update**

A joint evaluation report on the two extended opening hour's scheme is to be presented at the meeting. Action Closed.

### **Minute Number PCC329 – Wolverhampton CCG Update**

Ms Learoyd confirmed the details regarding the specific areas where patients feel they are not being provided with patient choice. Action closed.

**RESOLVED: That the above is noted.**

## **Governing Body Report/Primary Care Strategy Committee Update**

WPCC29 Mrs Southall presented to the Committee the Primary Care report that was present to the Governing Body meeting in April 2017 along with the minutes from the Primary Care Strategy Committee.

Ms Roberts queried the timescales for the programme, it was highlighted there are time limited individual programmes of work within each of the 7 Task and Finish Groups.

**RESOLVED: That the above is noted.**

## **Primary Care Operational Management Group Update**

WPCC30 Mr Hastings provided the following update as the meeting of the Primary Care Operational Management Group Meeting for April 2017 was cancelled;

- The Primary Care Contract Monitoring visits continue and a schedule for the next six months have been arranged.
- The demand management programme of work has been sent to NHS England performance team.
- The Local Estates Forum (LEF) are due to meet this week and they continue to discuss the Locality Hubs and clinical requirements.
- The Zero Tolerance Policy commenced as of the 1<sup>st</sup> April 2017 and there are currently 12 patients on the scheme.

**RESOLVED: That the above is noted.**

## Extended Opening Hours Schemes Joint Evaluation Report

WPCC31 Mrs Southall presented the Improving Access in Primary Care 2016/2017 report to the Committee. The report provided an overview of the three WCCG extend access schemes during December 2016 to March 2017. The three schemes were as follows;

- A&E Delivery Board (CCG) Christmas and New Year funded opening scheme.
- NHS England Winter Pressures
- CCG Extended winter pressures offering additional appointments from the 4<sup>th</sup> March – 31<sup>st</sup> March 2017.

Mrs Southall outlined an overview in terms of finance and performance for each scheme and noted it had varied in respect of patient attendance. The following points were highlighted;

- Varied performance for Christmas and New Year CCG Scheme, 91% utilisation on 5 dates made available to patients which would not normally be available, this included Christmas Eve and New Years Eve.
- 94% total attendance rate of patients overall during Winter Pressures NHS England Scheme.
- Extended Winter Pressures - CCG Scheme (64% attendance rate of patients attending extra slots on Saturdays, and 75% weekdays).

It was noted that some of the Practices who are considering how they move forward with extended access into 2017/2018 have considered guidelines from the General Practice Transformation Fund. This asks practices to identify how they will best meet their patients' needs by providing 20mins per 1000 patients to improve access during the year. This will be achieved through working at scale and the practice groups have submitted development plans which demonstrate how practices intend to work at scale and provide additional appointments in the evening instead of Saturday as the outcomes were so variable.

It was queried by the Committee if they will measure whether the schemes reduced the A&E activity during this time. It was highlighted that from patient experience survey undertaken it was indicated if an appointment was not available, patients would have gone to A&E. It was agreed to cross reference the data with A&E attendance in order to extrapolate what a high risk run rate would be for this time of year.

Ms Roberts raised her concerns regarding the equality of services and asked if they are planning any further extended access schemes that all practices can take part. Ms. Southall noted the issue of consistency was highlighted at the start, in terms of the bank holidays all practices have been provided with the opportunity to take part and they all took part, however not all practices opened for both bank holidays. There is the intention to work towards achieving this.



**RESOLUTION: Ms Southall agreed to cross reference the data with A&E attendance in order to extrapolate what a high risk run rate would be for this time of year.**

**Any Other Business**

WPCC33 There were no further discussion items raised by Committee or members of the public.

**RESOLVED: That the above is noted.**

WPCC32 **Date, Time & Venue of Next Committee Meeting**  
Tuesday 6<sup>th</sup> June 2017 at 2.00pm in PC108, 1<sup>st</sup> Floor, Creative Industries, Wolverhampton Science Park

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**WOLVERHAMPTON CLINICAL COMMISSIONING GROUP**

Minutes of the Primary Care Strategy Committee

Held on Thursday 20<sup>th</sup> April 2017

Commencing at 1pm in the CCG Main Meeting Room, Wolverhampton Science Park,  
Glaiser Drive, Wolverhampton

**Present:**

Steven Marshall	Director of Strategy & Transformation (Chair)
Sarah Southall	Head of Primary Care, WCCG (Vice Chair)
Vic Middlemiss	Head of Contracting & Procurement, WCCG
Jane Worton	Primary Care Liaison Manager, WCCG
Tally Kalea	Commissioning Operations Manager, WCCG
Dr Kainth	Locality Lead/New Models of Care Representative, WCCG
Dr Mehta	LMC Chair
Dr Reehana	Locality Lead/New Models of Care Representative, WCCG
Ranjit Khular	Primary Care Transformation Manager, WCCG
Jason Nash	New Models of Care Project Manager, WCCG
Jane Woolley	Project Manager Office Lead, WCCG
Hemant Patel	Deputy Medicines Optimisation Manager, WCCG
Laura Russell	Primary Care PMO Administrator, WCCG
Matthew Boyce	Primary Care Development Manager, WCCG
Liz Hull	Administrative Officer, WCCG

**Declarations of Interest**

PCSC124 Dr Mehta, Dr Kainth and Dr Reehana declared their interest, as GP's in items related to Primary Care. However, as declarations did not constitute a conflict of interest, they all remained in the meeting whilst these items were discussed.

**Apologies for absence**

PCSC125 Apologies were submitted on behalf of Dr Helen Hibbs, Claire Skidmore, Manjeet Garcha, Mike Hastings, Stephen Cook, Andrea Smith, David Birch, Sharon Sidhu, Alvina Nisbett and Barry White.

**Minutes and Actions**

PCSC126 The minutes of the previous meeting held on 8<sup>th</sup> March 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

PCSC127 Outcomes of Discussions – Report to Governing Body of the Primary Care Strategy Committee:

The Committee was informed that the report was accepted at the Governing Body Meeting on Tuesday 11<sup>th</sup> April 2017.

**RESOLVED: That the above was noted.**

PCSC128 Primary Care Strategy Communication Plan – attachment not provided, deferred to the next meeting.

**RESOLUTION: Action PCSC72 to remain open.**

## Risk Register

PCSC129 Escalation of Risks (Risks Scoring 15-25)

It was confirmed that there were no red risks to escalate to the Committee.

Summary of Risk Logs:

Risk logs for the following Task and Finish Groups were reviewed by the Committee:

- Capital Review Group / Strategic Estates Forum
- Primary Care Project Management
- Localities as Commissioners
- Clinical Pharmacist in Primary Care
- Workforce Development – Concerns were noted in relation to the Programme of Work.

**RESOLUTION: Deep Dives have been arranged for each Task and Finish Group. The Workforce Development Task and Finish Group is scheduled to take place on 18<sup>th</sup> May 2017 to challenge progress and ensure that the Programme of Work reflects the need to create a sustainable workforce.**

**Risk logs for all 7 Task and Finish Groups to be reviewed at the next meeting.**

**Action – All Risk Logs to be updated and submitted prior to the next meeting.**

## Performance

### PCSC130 Strategy Implementation Plan

Ms Russell provided the Committee with an update and confirmed that all high level objectives, due in April, have been completed. However, slippage was noted in the following areas:

- Back office function review
- Localities as Commissioners Development – exception reports to be presented and the plan to be updated with timescales in relation to MDT Working.

**RESOLVED: That the above was noted.**

### PCSC131 PMO Process Update

Ms Woolley referred the Committee to the amended process and reiterated the importance of the correct documentation being completed and being submitted to the relevant Programme Boards and Committee for approval.

**RESOLVED: That the above was noted.**

## Task & Finish Groups

### PCSC132 Practice as Providers Task & Finish Group

Mr Khular provided the Committee with a summary of discussions that took place at the Task and Finish Group on 21<sup>st</sup> March 2017.

An Exception Report was presented, which indicated that whilst progress has been made in several clinical areas, the full series of business cases and pathways have not been developed as per the intended plan - Actions / Options were noted as follows:

- Discussions have been held with the New Models of Care Leads.
- As new ideas are being generated by the Practice Groupings other areas of development will emerge from these discussions which will be taken forward and initial business cases drafted.

**RESOLUTION: Mr Khular to ensure that all Practice Managers are aware that the COPD / Asthma extended service is continuing. A review of the timescales for actions 4.2 and 4.3 on the Implementation Plan to be completed. Clarification required with regards to Neuro Rehab.**

**PCSC133 New Models of Care (Primary Care Home) Task & Finish Group**

Ms Southall presented an update on behalf of Mr White.

**RESOLUTION:** Ms Woolley to liaise with Mr White about missing information on the Implementation Plan.  
Ms Southall to liaise with Mr White about the length of the Gap Analysis.

**PCSC134 New Models of Care (Unity) Task & Finish Group**

Mr Nash referred the Committee to a highlight report.

The Committee was advised that the information in relation to the bid for NHSE funding to recruit clinical pharmacists within Primary Care, was out of date and that there would be another opportunity to bid in May.

*Mr Patel left and returned to the room.*

Dr Mehta raised concerns with regards to the GPFV Incentive Scheme and contractual hours for ANP's Practices to ensure that they are not paid twice.

No exceptions were reported.

**RESOLUTION:** Mr Nash to ensure that the concerns raised by Dr Mehta are addressed as part of the delivery plan.

**PCSC135 New Models of Care (Primary & Acute Care Service / Vertical Integration)**

Ms Southall had met with the Vertical Integration Primary Care Directorate Manager (Ms Nisbett) who had agreed to attend future Primary Care Strategy Committee meetings to improve collaborative working in relation to the GP Forward View and the CCG's Primary Care Strategy.

A report was not submitted nor was there any representation from Vertical Integration.

**RESOLUTION:** That the above is noted and Ms Hull to check if there would be representation at future meetings.

*Ms Southall left the room.*

**PCSC136 Localities as Commissioners Task & Finish Group**

Mr Khular provided the Committee with an update.

**RESOLUTION:** Ms Skidmore and Mr Hastings to liaise with Sultan Mahmud with regards to a query about RWT providing an incentive, to reduce A&E admissions, for Vertical Integration practices.

*Ms Southall returned to the room.*

The following exception reports were presented to the Committee:

- Exception Report 1 – Objective: Practice insight into the needs of their practice population.
  - The project was due to be completed by the end of March 2017.
  - Agreed to extend the deadline to the end of June 2017.

**RESOLVED: That the above is noted.**

- Exception Report 2 – Objective: Development of a locally enhanced service to ensure practices undertake Risk Stratification and establish robust links with their respective community neighbourhood teams.
  - The multi-disciplinary workshop has not yet been arranged due to a member of staff in Adult Community Services being on extended leave.
  - Since the objective was written, the DES for avoiding unplanned admissions has been abolished. From 1<sup>st</sup> July 2017 practices will use an appropriate tool to identify patients aged 65+ who are living with moderate and severe frailty. For those patients, the Practice will be required to deliver a clinical review in line with requirements.
  - A meeting with relevant stakeholders will take place by the end of June to consider how the new contractual requirements can be met by practices and MDTs from July 2017.

**RESOLVED: That the above is noted.**

*Dr Mehta left and returned to the room.*

- Exception Report 3 – Objective: Ensure that new clinical networks / practices working at scale have organisational and business requirements in place as commissioning entities.

**RESOLUTION: The timescales for this objective will be reviewed following the outcome of the Members Meeting on 26<sup>th</sup> April 2017.**

**PCSC137 Workforce Development Task & Finish Group**

The papers were not discussed due to the planned Deep Dive.

**RESOLVED: That the above is noted.**

**PCSC138 Clinical Pharmacist in Primary Care Task & Finish Group**

Mr Patel referred the Committee to the Highlight Report.

**RESOLVED: That the above is noted.**

**PCSC139 Primary Care Contracting Task & Finish Group**

Mr Middlemiss talked the Committee through the highlight report. It was noted that:

- Gill Shelley will commence in the Contracts Manager post from 3<sup>rd</sup> May 2017.
- Implementation of the full delegation plan will be monitored via the Primary Care Contracting Task and Finish Group.

**RESOLVED: The Committee noted the update provided.**

**PCSC140 Estates Development Task & Finish Group**

Mr Kalea updated the Committee with highlights from the Estates Development Task and Finish Group.

**RESOLVED: That the above is noted.**

**PCSC141 IM&T Business Intelligence Task & Finish Group**

Mr Kalea presented the highlight report to the Committee and confirmed that since the report had been produced, the revised version of Wolverhampton Local Digital Roadmap has been approved.

**RESOLVED: That the above is noted.**

**PCSC142 General Practice 5 Year Forward View**

Ms Southall referred the Committee to the training tracker and advised that a detailed report will be submitted to the next Committee.

**RESOLVED: That the above is noted.**

**PCSC143 Discussion Items**

There were no separate discussion items.

**RESOLVED: That the above is noted.**

**PCSC144 Any Other Business**

Primary Care Strategy Committee – Submission of Reports / Plans: Ms Woolley reiterated the importance of submitting reports / plans on time.

**RESOLVED: That the above is noted.**

Zero Tolerance Service – Ms Southall confirmed that the new service will be in place from 1<sup>st</sup> May 2017 and handover from the current provider would commence on 24<sup>th</sup> April 2017.

**RESOLVED: That the above is noted.**



**Date of next meeting**

Thursday 18<sup>th</sup> May 2017 at 1.00pm – 3.00pm in the CCG Main Meeting Room,  
Wolverhampton Science Park

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# Health and Wellbeing Board

Minutes - 29 March 2017

## Attendance

### Members of the Health and Wellbeing Board

Councillor Roger Lawrence	Leader of the Council (Chair)
Councillor Sandra Samuels OBE	Cabinet Member for Adults
Councillor Paul Sweet	Cabinet Member for Public Health and Wellbeing
David Baker	West Midlands Fire Service
David Watts	Service Director - Adults
Ros Jervis	Service Director - Public Health and Wellbeing
David Loughton	Royal Wolverhampton Hospital NHS Trust
Jeremy Vanes	Royal Wolverhampton Hospital NHS Trust
Chief Supt Jayne Meir	West Midlands Police
Bhawna Solanki	University of Wolverhampton
Helen Child	Third Sector Partnership
Linda Sanders	Strategic Director - People
Steven Marshall	Wolverhampton Clinical Commissioning Group
Alan Coe	Wolverhampton Safeguarding Board
Dr Helen Hibbs	Wolverhampton City Clinical Commissioning Group

### Employees

Helen Tambini	Democratic Services Officer
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## Part 1 – items open to the press and public

<i>Item No.</i>	<i>Title</i>
1	<p><b>Apologies for absence</b> Apologies were received from the following members of the Board: Alistair McIntyre – Locality Director – NHS England (West Midlands) Councillor Val Gibson – Cabinet Member for Children and Young People Councillor Paul Singh – Shadow Cabinet Member for Public Health and Wellbeing Dr Alexandra Hopkins – University of Wolverhampton Tim Johnson – Strategic Director – Place Tracy Taylor – Black Country Partnership NHS Foundation Trust</p>
2	<p><b>Notification of substitute members</b> Bhawna Solanki attended on behalf of Dr Alexandra Hopkins.</p>
3	<p><b>Declarations of interest</b> There were no declarations of interest.</p>
4	<p><b>Minutes of the previous meeting - 15 February 2017</b></p>

That, subject to the amendments referred to below, the minutes of the meeting held on 15 February 2017 be confirmed as a correct record and signed by the Chair:

- The inclusion of Bhawna Solanki in the list of apologies.
- The deletion of Chief Supt Jayne Meir from the list of attendees and her inclusion in the list of apologies.

5 **Matters arising**

The Chair thanked the Board for its comments on the Early Years Strategy and confirmed that it had been approved by the Cabinet.

Linda Sanders, Strategic Director – People, referred to the Better Care Fund and confirmed that the Council was still awaiting Government guidance and once that had been received the Board would be updated.

The Chair referred to the Forward Plan and noted that several reports had been deferred. He referred to the need to ensure the effective management of the Forward Plan and noted that the issue would be discussed further under the Forward Plan item.

6 **Sustainability and Transformation Plan (STP) - Update and Local Health and Care System next steps**

Dr Helen Hibbs, Chief Officer, Wolverhampton Clinical Commissioning Group (CCG), David Loughton, Chief Executive, Royal Wolverhampton Hospital NHS Trust and Linda Sanders, Strategic Director – People presented the report.

The Strategic Director – People introduced the item and referred to the work already undertaken by the Transition Board and its evolution into a Systems Development Board. She referred to the anticipated announcement by the Head of NHS England, Simon Stevens on Friday, 31 March, outlining future proposals for the health service and the implications that might have for Wolverhampton and the wider Black Country. She expected that there would be a renewed commitment to Sustainability and Transformation Plans (STPs), moving into a new phase with the appointment of a System Leader for the Black Country to drive change. Work was already ongoing with the Chief Officer and Chief Executive to ensure that local residents continued to receive the best service possible. It was vital that the service remained cohesive and resilient.

The Chief Officer referred to the ongoing attempts to reorganise the NHS and the difficulties ahead. Discussions locally had taken place looking at a place-based model of care to tie into the wider Black Country model. Information relating to the new System Leader post continued to change and it was unclear if an incumbent would take the post. A joint committee comprising the four Black Country CCGs had held its initial meeting and established several Task and Finish Panels.

The Chief Executive referred to the forthcoming great structural changes required to achieve the targeted reductions of £900 million. During this period of considerable change there was a great opportunity for Wolverhampton to take the lead, with so many significant changes taking place just outside Wolverhampton.

The Service Director – Public Health and Wellbeing referred to the uncertain future and the importance of regular dialogue as issues emerged to ensure that appropriate time was given to understand and support the development of the system for local people.

The Board was concerned about acute hospital bed provision in the region and sought assurance regarding its future.

Steven Marshall, Director of Strategy and Transformation, Wolverhampton Clinical Commissioning Group stated that although significant savings would have to be made and there was a great deal of speculation, there was no plan in place for hospital closures in the area.

The Chief Officer confirmed that as part of the STP there would be increased community care and to allow that, resources would need to be released from acute hospital beds. There would need to be economies, different working practices, and early intervention to allow that to happen.

Jeremy Vanes, Chair, Royal Wolverhampton Hospital NHS Trust stated that the Trust Board had spent time trying to prepare for future changes. The emphasis would be on sustaining health improvements rather than structure and although any changes would be orchestrated nationally, it would have to be delivered locally.

The Strategic Director – People referred to a press statement which had been drafted and asked the Board for guidance regarding a release date.

The Board acknowledged that until an announcement had been made, hopefully on Friday there would be many unanswered questions and until that announcement was made, it would be advisable to wait to make any announcements or release a press statement.

Resolved: The Board noted the issues connected to the development of care and health systems in the City of Wolverhampton in the light of the update on the next steps for the Black Country Sustainability and Transformation Plan.

7

### **Health and Wellbeing Board - Forward Plan 2016/17**

Ros Jervis, Service Director – Public Health and Wellbeing introduced the report.

The Service Director – Public Health and Wellbeing referred to the letter from the Chair circulated to all members of the Board regarding proposed changes to how agendas for future meetings were set to ensure a strong strategic focus was maintained. It was proposed to establish an Agenda Group of core members which would meet a month before each meeting and members of the Board were encouraged to feed through any ideas which would be considered by that Group. Feedback to the proposals had been positive so far and any additional feedback was welcomed.

The Chair confirmed that there would be quarterly meetings and a development day in October. The Agenda Group would allow more effective planning for future agendas.

The Board referred to the forthcoming announcement by Simon Stevens on future proposals for the health service and suggested that an update report to reflect any possible impact from that statement on the Sustainability and Transformation Plan (STP) should be submitted to the next meeting in June.

Alan Coe, Chair of the Wolverhampton Safeguarding Board referred to how the phasing of the Safeguarding Boards would fit into the Plan and the Board suggested that those timings should also be considered.

Resolved:

1. The Board approved the current Forward Plan.
2. The Board requested a report on the STP detailing any updates in response to the forthcoming announcement from the Head of NHS England to be submitted to the next meeting of the Board in June.
3. The Board consider the timings for the phasing of the Safeguarding Boards into the STP at an appropriate time.

## 8 **NHS Capital Programme - Updates**

A request had been received prior to the meeting for the report title to be changed to Estates Update and for the report to be deferred to the next meeting.

Resolved:

1. That the report title be changed to Estates Update.
2. That the item be deferred to the next meeting of the Board in June.

## 9 **Evaluation Feedback on Living Well, Feeling Safe Event**

Ros Jervis, Strategic Director – Public Health and Wellbeing and David Watts, Service Director – Adults presented the report.

The Service Director – Public Health and Wellbeing introduced the report and stated that the event had proved extremely successful in engaging with both partners, community groups and local residents and had been very well received, with considerable positive feedback. Suggestions had also been received for any future events and it was important not to lose momentum and to consider the way forward.

The Service Director – Adults referred to the importance of engaging at a local level and working with local communities. The event had also highlighted local knowledge which had added value to the event. In future events could be themed to target problems highlighted in specific areas.

The Board referred to large community events held annually in various locations, including Durham but considered that, smaller, more frequent, localised events were more beneficial as local communities and neighbourhoods could relate to them more. It was also important that the impetus between events was not lost, which could happen when annual events were held.

Alan Coe, Chair of Wolverhampton Safeguarding Board stated that it was important to help the socially isolated who were prone to vulnerability and it would be helpful to identify what local people found helpful when such events were held and any input from Stephen Dodd from the Wolverhampton Voluntary Sector Council would be advantageous.

Chief Supt Jayne Meir, West Midlands Police referred to the Active Citizens Funding of £80,000 to be awarded to community groups towards crime prevention and resilience and it was hoped in the future to become increasingly involved in community activities.

The Service Director – Public Health and Wellbeing confirmed that the Steering Group was Chaired by Stephen Dodd and a representative from the Police would be invited to the next meeting on 12 April.

In answer to a question regarding GP involvement, the Service Director – Public Health and Wellbeing confirmed that the Clinical Commissioning Group was well engaged and help would be given to improve engagement with GPs.

Resolved:

1. The Board noted the feedback from the Living Well, Feeling Safe Event.
2. The Board receive a range of options for further events at a future development session.

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**WOLVERHAMPTON CITY CLINICAL COMMISSIONING GROUP**  
**Governing Body Meeting**  
**Tuesday 11 July 2017**

<b>TITLE OF REPORT:</b>	<b>Annual Quality and Risk Report (2016/17)</b>
<b>AUTHOR(s) OF REPORT:</b>	Steven Forsyth, Head of Quality and Risk
<b>MANAGEMENT LEAD:</b>	Steven Forsyth, Head of Quality and Risk
<b>PURPOSE OF REPORT:</b>	<p>To share with the committee a reflective annual report regarding the undertaking of the clinical quality monitoring framework, also including performance against clinical indicators for the reporting period 1st April 2016 to 31st March 2017 (reported by exception).</p> <p>The report provides a position statement based on safety, experience and effectiveness for the period 1st April 2016 to 31st March 2017 and will enable Committee to be updated on the work that has been undertaken by the Quality and Risk team during that period.</p>
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> <b>Decision</b> <input checked="" type="checkbox"/> <b>Assurance</b>
<b>PUBLIC OR PRIVATE:</b>	This report is confidential due to the sensitivity of data and level of detail.
<b>LINK TO CCG Governing Body Strategic Objectives</b>	<ol style="list-style-type: none"> <li>1. Improving the quality and safety of the services we commission</li> <li>2. Reducing Health Inequalities in Wolverhampton</li> </ol>

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## 1. PURPOSE OF THE REPORT / INTRODUCTION

The CCG commissions many healthcare services from a range of providers, our two biggest contracts are with The Royal Wolverhampton NHS Trust (RWT) and Black Country Partnership (NHS) Foundation Trust (BCPFT). During 2016/17 there have been a variety of challenges which we have worked on from 2015/16 and seen demonstrable improvements in the reduction of pressure injuries and a reduction in serious incidents causing harm. However, further work continues in other key areas as reducing falls and information governance breaches particularly at The Royal Wolverhampton NHS Trust. Black Country Partnership Foundation Trust has seen a marginal increase in the type of serious incidents reported, we are working with this provider to see how lessons learnt can impact on incidents occurring with regular themes and/or trends.

Success this year has varied with the continued and sustained improvement in patient safety initiatives, improved patient experience, improved patient/user engagement, consultation and safeguarding measures for vulnerable adults and children in Wolverhampton.

The CCG continues to support the domains of the NHS Outcomes Framework:

- preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

Whilst the CCG strives to lead by example, both main providers are signed up to advocating pledges outlined in the „Sign up to Safety“ campaign, the CCG's five pledges are to:

Put Safety First – commit to reducing avoidable harm in the NHS by half, including:

- reducing harm from avoidable falls
- reducing harm from avoidable pressure injuries
- reducing harm through implementation of Sepsis 6
- preventing avoidable admissions to hospital
- management of long-term conditions in primary care and the community

Continually learn – make the organisation more resilient to risks by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.

Honesty – be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

Collaborate – take a leading role in supporting local collaborative learning, so that improvements are made across all the local services that patients use.

Support – help people to understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

The Annual Quality and Safety Report demonstrates how each area has been assured and work continues to foster care of the highest possible standard and that in the event of serious incidents there is continued organisational learning that is embedded in revised clinical practice.

I commend the report to you and once again wish to thank the Quality Team for all their continued efforts to improve quality of services for all people of Wolverhampton.

**Steven Forsyth**  
**Head of Quality and Risk**

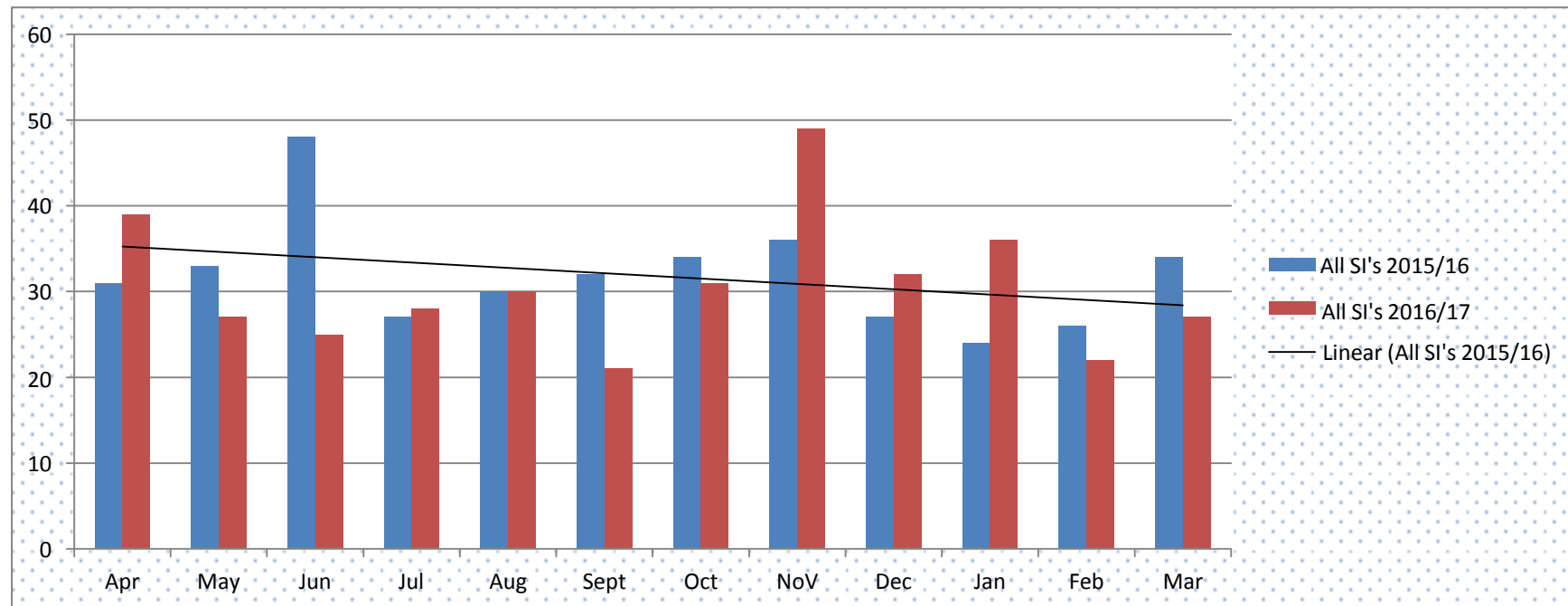
Date 3<sup>rd</sup> May 2017

## 2. ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST

### 2.1 RWT Serious Incidents reported for 2016/2017 (including Pressure Injuries)

Table 1 to show RWT all SI's reported for 2015/2016 - 2016/2017

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
All SI's 2015/16	31	33	48	27	30	32	34	36	27	24	26	34	382
All SI's 2016/17	39	27	25	28	30	21	31	49	32	36	22	27	367



**Number of RWT admissions** for 2016/2017 = Estimated 104301 patients (March 2017 data not available but average admission per month is 8692 patients) compared to 104923 patient admissions in 2015/2016.

**Number of RWT discharges** for 2016/2017=Estimated 104925 patients (March 2017 data not available but average discharges per months is 8744 patients) compared to 104999 patients in 2015/2016.

In 2016/2017 a total of 367 serious incidents that met the reporting criteria were reported by RWT which is a slight reduction compared to 382 reported in 2015/2016. On average there are 30 serious incidents reported per month for 2016/2017 but there was a significant increase in serious incidents reported for the month of April (39) and November (49). This relates to increase in pressure injury and information governance serious incidents reported for these two months. A full breakdown of these serious incidents reporting profile for 2016/2017 is available in Table 2 below.

**Table 2 to show: 2016/17 RWT Serious Incident Reporting profile**

2016/17	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total	Overall %
<i>Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria</i>						1	1						2	0.54%
<i>Confidential Information Leak</i>	5	2	4	4	5	3	4	11		3			41	12%
<i>Diagnostic Incident / Delay.</i>	1	2				2	1		2	1	2	2	13	3.54%
<i>HCAI/Infection control incident meeting SI criteria</i>	2	1	1	3	1	1		2	2	2	1	2	18	5%
<i>Maternity / Obstetrics incident -SI criteria (Mother only)</i>	1	1							1				3	0.81%
<i>Maternity / obstetric incident -SI criteria (baby only)</i>	2		1		1		1	1					6	1.67%
<i>Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus. neonate and infant)</i>						2							2	0.54%
<i>Maternity/Obstetric incident meeting SI criteria</i>										1			1	0.27%
<i>Medication Error</i>	1								1				2	0.54%

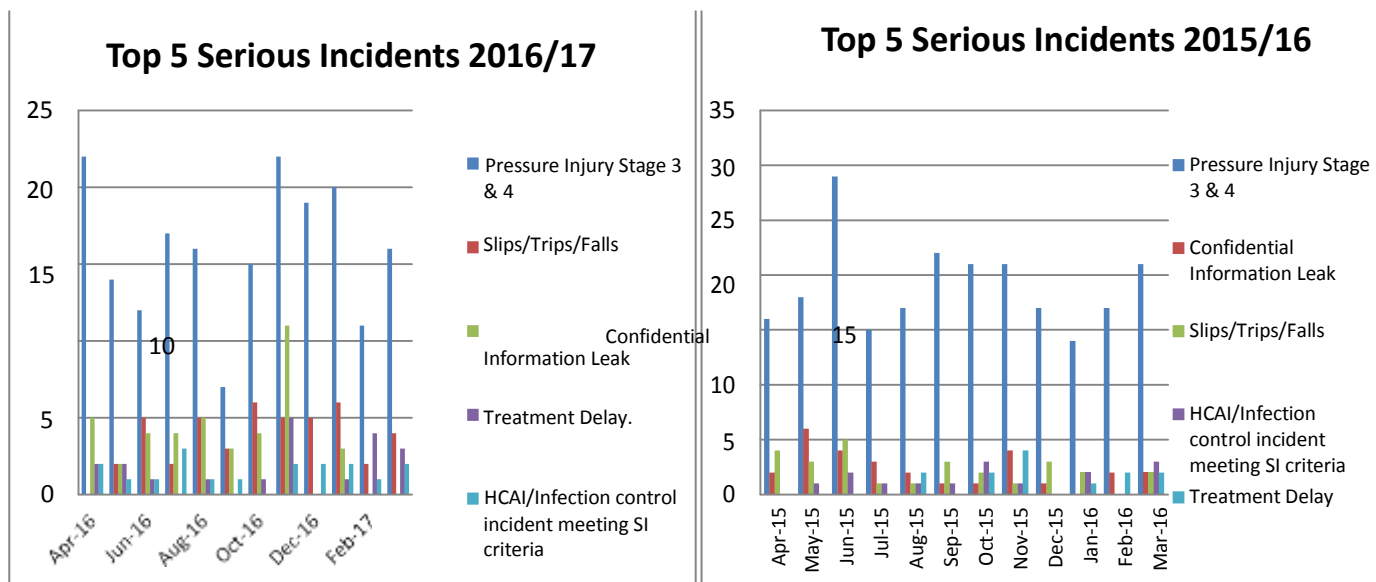
2016/17	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total	Overall %
<i>Operation/treatment given without valid consent</i>		1											1	0.27%
<i>Pending review (category selected before incident is closed)</i>	2	1		2	1		1	3		1	2		13	3.54%
<i>Pressure Injury Stage 3&amp;4</i>	22	14	12	17	16	7	15	22	19	20	11	16	191	52%
<i>Radiation incident (including exposure when scanning) meeting SI criteria</i>		1											1	0.27%
<i>Slips/Trips/Falls</i>		2	5	2	5	3	6	5	5	6	2	4	45	12%
<i>Surgical/invasive procedure incident meeting SI criteria</i>						1				1			2	0.54%
<i>Surgical Error</i>									1				1	0.27%
<i>Treatment Delay.</i>	2	2	1		1		1	5		1	4	3	20	5%
<i>Unauthorised absence</i>	1												1	0.27%
<i>Unexpected / Potentially Avoidable death</i>									1				1	0.27%
<i>Venous Thromboembolism (VTE)</i>			1			1	1						3	0.81%
<b>Grand Total RWT</b>	<b>39</b>	<b>27</b>	<b>25</b>	<b>28</b>	<b>30</b>	<b>21</b>	<b>31</b>	<b>49</b>	<b>32</b>	<b>36</b>	<b>22</b>	<b>27</b>	<b>367</b>	<b>100%</b>



**Table 3 - Top 5 Serious Incidents reported for 2016/17**

<b>2016/17</b>	<b>Apr-16</b>	<b>May-16</b>	<b>Jun-16</b>	<b>Jul-16</b>	<b>Aug-16</b>	<b>Sep-16</b>	<b>Oct-16</b>	<b>Nov-16</b>	<b>Dec-16</b>	<b>Jan-17</b>	<b>Feb-17</b>	<b>Mar-17</b>	<b>Total</b>	<b>Overall %</b>
<i>Pressure Injury Stage 3 &amp; 4</i>	22	14	12	17	16	7	15	22	19	20	11	16	<b>191</b>	<b>60.63%</b>
<i>Slips/Trips/Falls</i>		2	5	2	5	3	6	5	5	6	2	4	<b>45</b>	<b>14.28%</b>
<i>Confidential Information Leak</i>	5	2	4	4	5	3	4	11		3			<b>41</b>	<b>13.1%</b>
<i>Treatment Delay.</i>	2	2	1		1		1	5		1	4	3	<b>20</b>	<b>6.34%</b>
<i>HCAI/Infection control incident meeting SI criteria</i>	2	1	1	3	1	1		2	2	2	1	2	<b>18</b>	<b>5.71%</b>
<b>Total of All SI's 2016/17</b>	<b>31</b>	<b>21</b>	<b>23</b>	<b>26</b>	<b>28</b>	<b>14</b>	<b>26</b>	<b>45</b>	<b>26</b>	<b>32</b>	<b>18</b>	<b>25</b>	<b>315</b>	<b>86%</b>

**Table 4 – to show comparison of SI's 16/17 with 15/16**

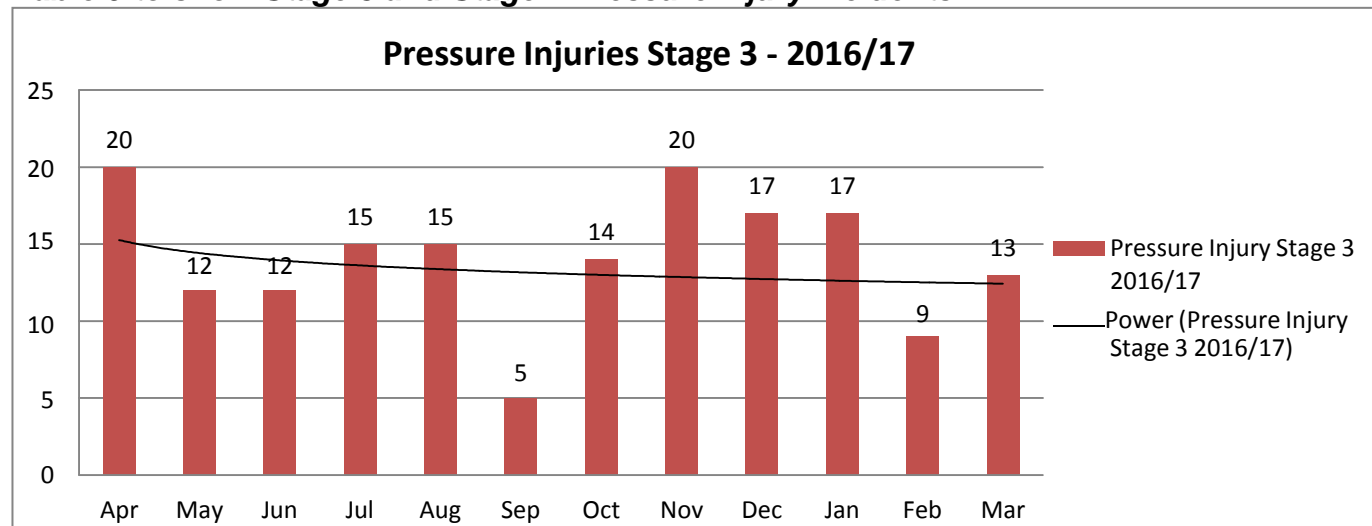


Pressure Injury (PI) serious incidents remain the highest reported category for 2016/2017 at 52% followed by slip, trip falls (12%), confidential information leak (11%), treatment delay (5%) and Infection prevention (5%) make the top 5 categories of serious incidents reported and these top five categories remains unchanged from those reported in 2015/2016 (Table 4).

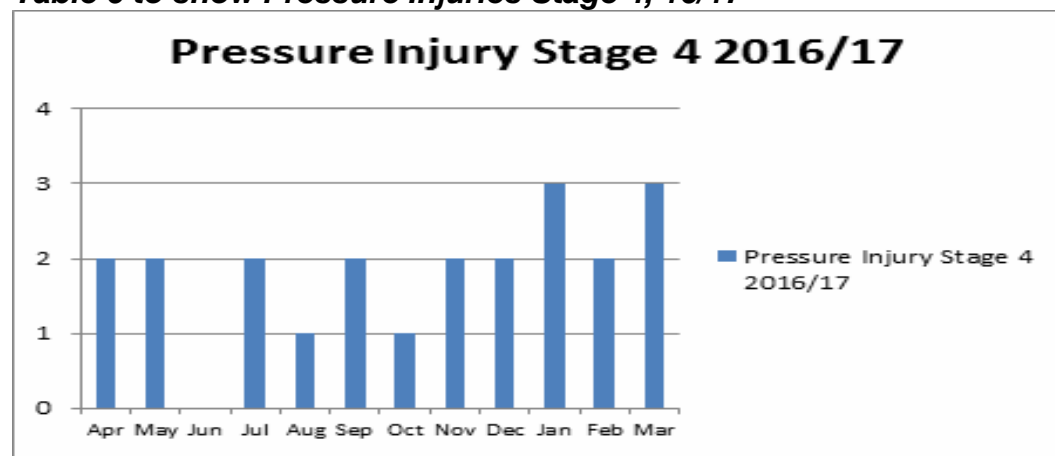
The remaining serious incidents by category for 2016/2017 can be viewed in Table 2 (pages 7 and 8).

## 2.2 Pressure Injuries

**Table 5 to show Stage 3 and Stage 4 Pressure Injury Incidents**



**Table 6 to show Pressure Injuries Stage 4, 16/17**



**Table 6a 2016/2017 Stage 3&4 Pressure Injury Accountability outcomes are detailed below:**

Unavoidable	105	54.97%
Avoidable	64	33.50%
De-escalated	5	2.61%
Deferred	1	0.52%
Awaiting Scrutiny	16	8.37%

A total of 191 PIs stage 3 & 4 were reported for 2016/2017 and a breakdown of stage 3 & stage 4 PIs is demonstrated in tables 2&3. This shows a reduction compared to 228 PIs reported in 2015/2016. Table 5 demonstrates a reduction in Stage 3 PI"s in comparison to 2015/16.

### **2.2.1 Themes emerging from Pressure Injury Incidents:**

- Gaps in patient repositioning and intervention charts
- Failure to accurately complete patient skin assessments and pressure injury gradings
- Failure to complete a non-concordance risk assessment
- Failure to escalate to senior staff/other members of the MDT
- Staffing and staff pressure injury training issues
- Delay in delivery of pressure relieving equipment

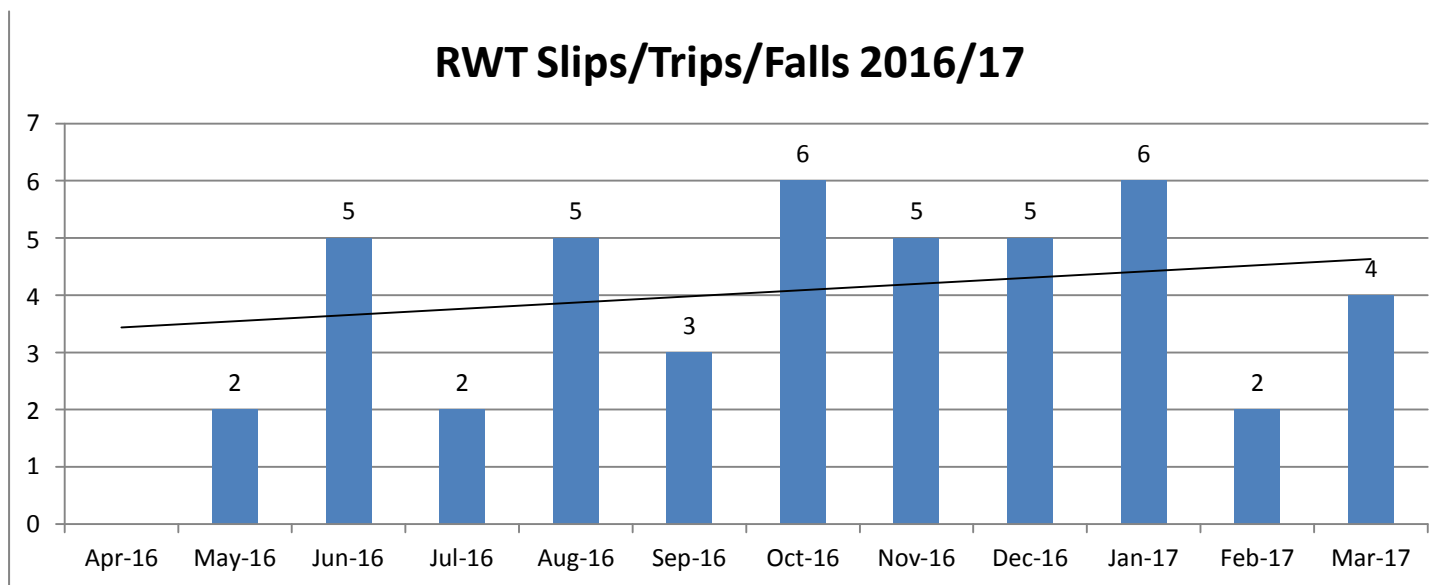
### **2.2.2 RWT Actions:**

- Weekly pressure injury scrutiny meetings led by The Royal Wolverhampton NHS Trust Chief Nurse and attended by CCG Quality & Safety Manager.
- Senior Ward Managers review paperwork for all high risk patients and undertake safety briefings on all shifts.
- Improved overall compliance with training.
- 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 the Trust, General Practices and Nursing Homes.

- Tissue Viability Steering Group and CCG are working on further analysis of trends and recommended best practice..
- CCG are developing a business case to support a Wound Centre of Excellence with an aim to improve the patient referral and care pathway within a community setting.
- Table top exercises to compare heel offloading devices.
- 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 has completed a table top exercise to agree the skin protectant for the formulary.
- 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 2017.
- Tissue Viability Lead Nurse is involved with a task and finish group for NHS improvement for definitions and measurements of pressure injuries.

### **2.3 Patient Slip/Trip/Falls**

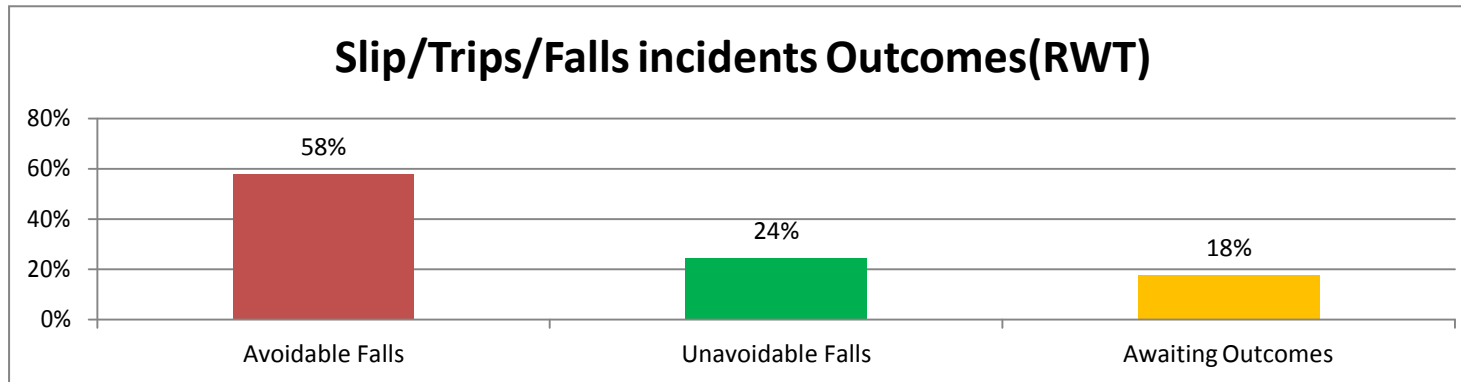
**Table 7 to show RWT Slips/Trips/Falls Category 16/17**



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The Trust reported 45 patient slip/trip/falls (meeting serious incident criteria) during 2016/2017 which is a significant increase in the number of falls reported in 2015/16 of 27 patient falls.

**Table 7a to show outcomes of Slip/Trip/Falls (RWT)**



### 2.3.1 Themes emerging post RCA

- Delay in medically fit patient discharges (a review of all patient moves has been requested)
- Inappropriate patients transfers within clinical areas
- Lack of staff training in falls management and risk assessment
- Failure to complete falls risk assessments
- Failure to follow Trust falls management and falls prevention policy

### 2.3.2 Trust Actions

- Internal and external patient falls audits
- Staff training and education
- Falls prevention and post falls policies have been revised and 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

## 2.4 Confidential Information Leak Incidents

There were 41 information governance incidents reported for 2016/2017 which is a significant increase compared to 28 IG incidents reported in 2015/2016. The Trust has developed a comprehensive action plan to mitigate risks associated with these incidents and to prevent these incidents recurring. WCCG is monitoring this closely and robust scrutiny has been applied by SISG (Serious Incidents Scrutiny Group).

## 2.5 Treatment Delays

There were 20 serious incidents reported for treatment delays and of these:

4 each were reported by Emergency Department & General Surgery

2 each were reported by Trauma & Orthopaedics & Urology

1 each were reported by Critical Care, Paediatrics, Cardio-Thoracic, Gynaecology, Oncology, Out-Patients, Neurology & ENT

The emerging themes were ***“failure to recognize, failure to act and failure to escalate the clinical condition of the patient”*** thus causing treatment delays. A robust root cause analysis has been undertaken by the Trust into all these serious incidents and appropriate actions have been undertaken to mitigate the risks and prevent these incidents happening again.

The Trust has engaged with an external reviewer as part of Emergency Department development plan by undertaking some work on addressing ED processes and human factors. This visit has been completed and the Trust is working on all recommended actions to improve Emergency Department Services.

WCCG is closely monitoring these incidents and robust scrutiny has been applied by Serious Incident Scrutiny Group for all these incidents.

## 2.6 Infection Prevention (IP)

### 2.6.1 HCAI/Infection control incident meeting SI criteria



There were 18 infection prevention incidents reported by the Trust for 2016/2017 which is a slight increase from 15 incidents reported in 2015/2016. 9 of these incidents relate to CDiff only and MRSA, Norovirus and Carbapenemase Producing Enterobacteriaceae (CPE) account for 2 incidents each and the other 3 incidents relate to failure to follow IP policy. The main identified themes for these IP incidents are failure to follow antimicrobial policy, environmental factors and failure to decontaminate the equipment appropriately. However, the Trust has undertaken comprehensive Root Cause Analysis into all these incidents and has developed comprehensive action plans to mitigate the risks associated with these incidents.

### **2.6.2 Actions taken by Trust:**

- Surveillance has been extended to identify any areas of crossover of types of Clostridium Difficile Infection in any time frame.
- Time to isolation has continued to improve, almost to the peak seen in 2014.
- RWT is now within control limits for the funnel plot for April 2016-present. Cases have returned to anticipated numbers in line with the monthly trajectory.
- Deep cleaning programme has been implemented.
- Technical cleaning update for very high and high risk areas.
- Disposable bed curtains and cleaning mops have been implemented.
- CPE strategy is in development to include a business case for molecular testing in the laboratory, full implementation of a risk assessment and screening process, and executive level awareness raising sessions are being rolled out.

### **2.6.3 Infection Prevention Statistics**

- **Clostridium Difficile**

The Trust was 9 cases over target at the end of February 2017 and has exceeded their external target of 35 cases for the year.

- **Carbapenemase Producing Enterobacteriaceae (CPE)**

The Trust has reported 17 new CPE positive patients during 2016/2017.

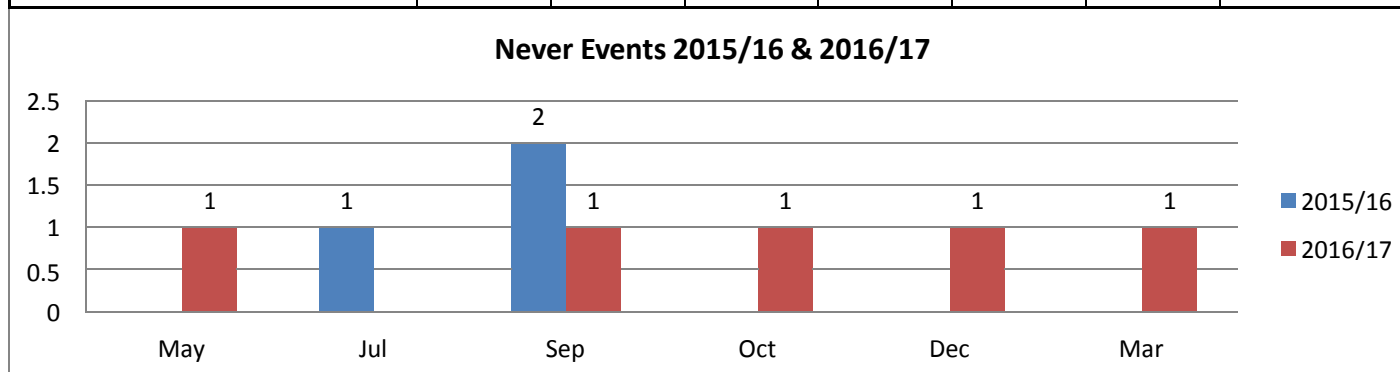
- **MRSA Bacteraemia**

At the time of writing this report RWT's target for the year is zero avoidable cases and they remain on target.

The remaining 14% of serious incidents reported for 2016/2017 relates mainly to pending review, diagnostic delays and maternity incidents and other 9 categories (Table 2) of serious incidents. The Trust has undertaken full RCAs into all these serious incidents to identify root causes and to identify learning actions to mitigate any risks associated with these incidents. All serious incidents are monitored and scrutinised by the WCCG Quality and Risk team.

## 2.7 Never Events Summary 2015/16 & 2016/17

Never Events reported	May	Jul	Sep	Oct	Dec	Mar	Total
2015/16		1	2				3
2016/17	1		1	1	1	1	5
Total	1	1	3	1	1	1	8



There were 5 Never Events reported by RWT for the 2016/2017 which is a slight increase from 3 Never Events reported in 2015/2016. These reported incidents relate to the following never event categories:

- Wrong implant/prosthesis (1)
- Retained foreign object post procedure(2)
- Wrong site surgery (2)

### 2.7.1 Themes emerging from Never Events:

- Human errors
- Failure to accurately complete the WHO surgical checklist
- Poor team communication
- Failure to follow the patient consent policy
- Poor record keeping (during surgery)

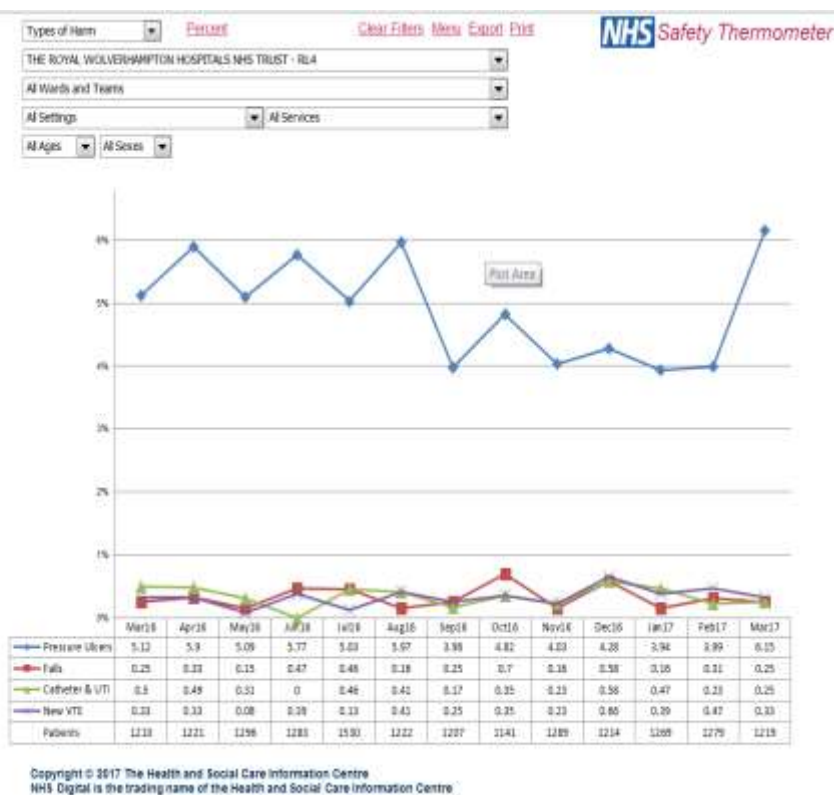
### **2.7.2 Actions taken**

- Shared wider learning throughout the Trust
- Staff training, assessment and improving awareness
- Regular audits
- Improve safety checks and record keeping during procedures

Two quality visits (1 x announced, 1 x unannounced) have been undertaken by the Quality Team to ensure effectiveness of actions and a full report has been shared with the provider with recommendations. A further never event associated Table Top Review Meeting has also been undertaken to review how practice has changed in the following areas: Maternity, Cardiothoracic Theatre, Eye Infirmary, Dental and Gynaecology.

WCCG is closely monitoring all incidents and robust scrutiny has been applied for each Never Event reported by the provider.

## 2.8 NHS Safety Thermometer



Pressure injuries continue to be the main harm recorded for RWT. RWT's Tissue Viability Steering Group and WCCG's Pressure Ulcer Steering Group are working on further analysis of trends and recommended best practice.

### 3. BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST

There were 27 incidents reported for 2016/2017 which is a slight increase compared to 25 incidents reported in 2015/2016. However, the reported serious incidents numbers have remained relatively similar for the last three years.

#### 3.1 BCPFT Serious Incidents reported for last three year period:

2014/2015: 24  
2015/2016: 25  
2016/2017: 27

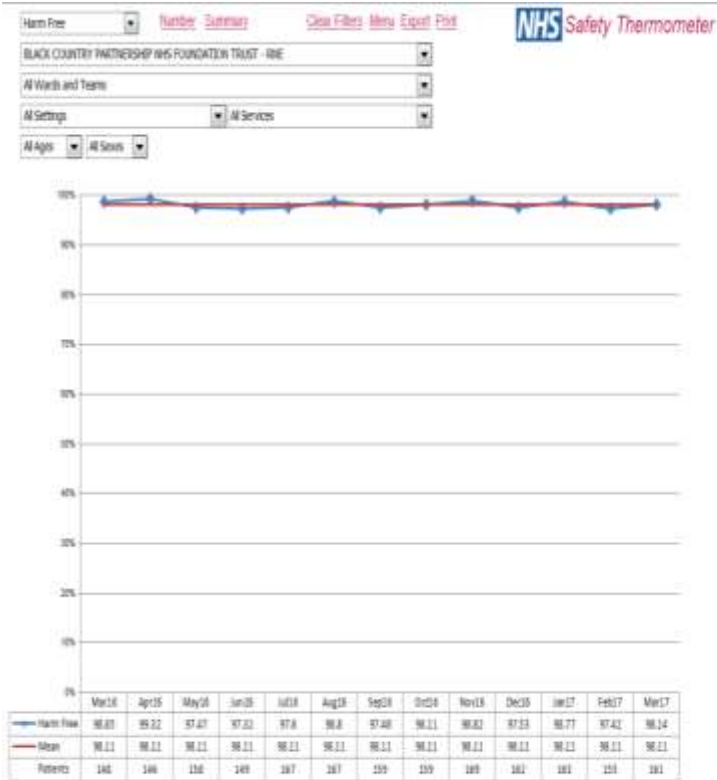
- The top three categories of reporting in 2016/2017 were: Pending review (13), Apparent/actual self-inflicted harm (5) and slip/trip/falls (4). The other serious incidents categories relates to pressure injury(1), Apparent/actual/suspected homicide meeting SI criteria(1), Sub-optimal care of the deteriorating patient meeting SI criteria(1), treatment delay(1) and confidential information breach (1).
- The Trust has undertaken comprehensive RCAs into all these serious incidents to identify root causes and to identify learning actions to mitigate the risks associated with all these serious incidents. WCCG Quality Team is closely monitoring these incidents and robust scrutiny has been applied prior to close these incidents.

#### 3.2 Learning actions

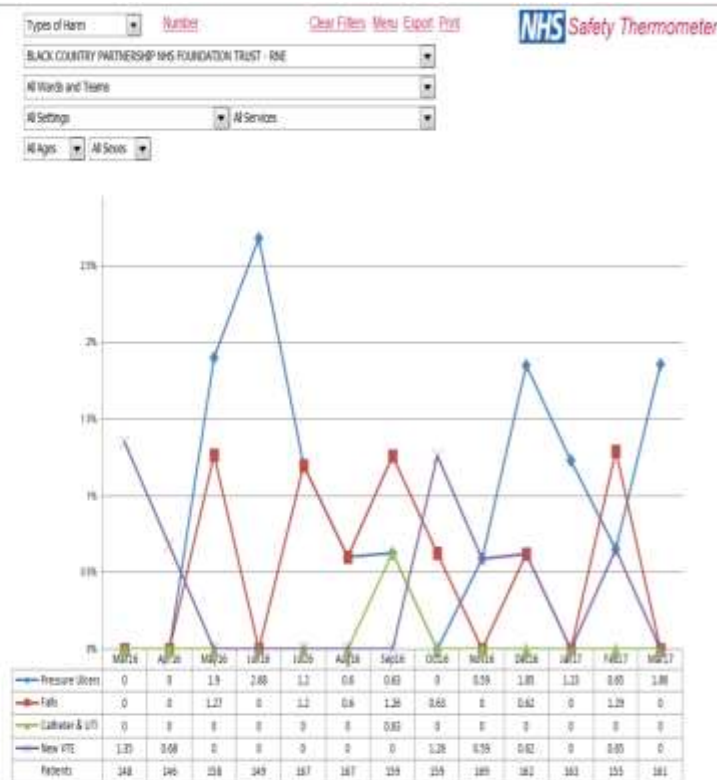
- The importance of aggregating key information through the care pathway.
- The need for timely and effective communication between services.
- Record keeping adherence to NMC record keeping standards and in accordance with Trust Clinical Record Keeping Standards Policy, including Electronic Health Records.
- Regular physical health monitoring requirements for patients had not been undertaken in accordance with recommendations from Royal College of Psychiatrists and NICE guidelines.
- The care clustering reviews had not been consistent and undertaken on at review opportunities.
- All clinic appointment cancellations/rescheduling or DNA"s should be recorded in the notes to produce a chronological record of contacts.
- Review of the referral process methodology.

- Improving staff education and training into physical assessment and escalation process.

### 3.3 NHS Safety Thermometer



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BCPFT's harm free care rate has remained high throughout 2016/17.

## **4. PRIVATE SECTOR – Serious Incidents**

### **4.1 Vocare (Urgent Care Centre)**

There were 9 serious incidents reported by Vocare for 2016/2017 with 8 out of these 9 incidents relating to treatment delay category and 1 incident relates to diagnostic delays category. Vocare has undertaken full RCAs into all these serious incidents to identify root causes and learning actions from these investigations to mitigate the risks associated with these serious incidents.

The themes emerging from these serious incidents are delays in providing care and treatment, failure to recognise patient clinical condition deterioration and staff mandatory training non-compliance. WCCG has also undertaken an announced clinical data quality visit to the Urgent Care Department and the initial report and actions required by Vocare has been shared with the provider.

WCCG Quality Team is closely monitoring all these serious incidents and applying robust scrutiny through SISG and monthly combined Contract and Quality Review Meetings. An announced comprehensive inspection visit to Vocare was carried out by CQC in March 2017. CQC and WCCG are working collaboratively and have formed an Improvement Board to resolve the key issues identified.

### **4.2 Compton Hospice**

There were 6 incidents reported for 2016/2017. These relate to Pressure Injury (4), Patient fall (1) and suboptimal care (1) categories. The themes emerging from these incidents relate to failure to complete skin assessments, omissions in care documentation and staff mandatory training issues. Compton has undertaken full RCAs into all these incidents to identify root causes and learning actions to mitigate the risks associated with these incidents. WCCG has undertaken an announced quality visit to review the patient falls and pressure injuries incidents management at Compton Hospice from a quality and safety perspective.

The actions identified from this visit were shared with the provider and they have developed a comprehensive action plan to resolve the issues identified. Compton Hospice is fully supported by WCCG Quality Nurse Advisors through regular visits and advice. WCCG Quality Team is closely monitoring all these serious incidents and applying robust scrutiny through SISG and through combined Contract and Quality Review Meetings.



### **4.3 Probert Court Care Home**

There were no serious incidents reported by this provider for 2016/2017. However, there were some medicine safety issues identified by the Quality Team through the combined Contract and Quality Review Meetings. Therefore, an unannounced quality visit was carried out by the Quality Team to review the medicine management safety at the Probert Court Care Home. There were potential medicine safety concerns identified by this visit and these concerns were shared with Probert Court Care Home.

Probert Court has developed a comprehensive action plan, supported by Quality Nurse Advisors and the Medicine Management team at WCCG. WCCG Quality team is closely monitoring the medicine management safety action plan through combined Contract and Quality Review Meetings and regular planned and unplanned visits by the Quality Nurse Advisors.

## 5. QUALITY VISITS

- Royal Wolverhampton Hospitals NHS Trust

*Table to show quality visits undertaken during 2016/17*

Clinical Quality Visiting Schedule (Commissioners including West Midlands Quality Review Service) - Acute 2016/17			
QUALITY VISIT PROGRAMME 2016/17- RWHT Acute & Community Contract			
Quarter	Type of Visit	Date & Time	Location/Review Type
Quarter 2	Announced	15th Sept 2pm to 5pm	Oncology Service
	Announced	26th September at 9.00 am	Urgent Care Centre/ED, follow up visit
Quarter 3	Announced	31st Oct at 9.00 am to 1.00 pm	Maternity Review (joint visit with Walsall CCG, South Staffs/Seadon CCG)
	Announced	14th November at 9.00 am to 1.00 pm	Never Event Assurance - Ophthalmology (Eye Infirmary)
	Unannounced	5th/10th December at 9.30 am	Re-visit to Ophthalmology (Eye Infirmary) to review service and pathway for Lucentis treatment
	Announced	19th December at 9.30 am to 1.30 pm	Cannock Chase Hospital, follow up visit
Quarter 4	Unannounced	9th January 2017 at 1.00 pm	Discharge Lounge (CIC), New Cross Hospital
	Announced	20th January 2017, 9.00 am to 1.00 pm	Cardiothoracic/Obstetrical/Gynaec/Dental - Never Event Assurance lessons learned and review of action plans
Quarter 1 2018	Announced**	Postponed from 18/17	Safeguarding Assurance (Children's and Adults)

Verbal feedback is shared with the provider immediately following each visit with draft written feedback shared within agreed timescales. Once agreed, final reports and action plans are discussed as part of the agenda at monthly Clinical Quality Review Meetings.

- **Black Country Partnership Foundation Trust**

The visiting schedule is spread across the Black Country Commissioners and Sandwell and West Birmingham lead on the planning of quality visits. We have successfully completed visits to: The Groves, Penn Hospital, Blakenhall Day Centre and undertaken a robust safeguarding assurance visit which included visiting GEM Centre, Meadow Ward, Pond Lane, Early Intervention and Adult Crisis.

- **Private Sector**

Quality visits were undertaken during 2016/17 to the following providers; Vocare, Compton Hospice, Probert Court and Concordia. In line with the quality visit process, verbal feedback was shared at the time of the visit with formal feedback shared and discussed at CQRM.

6. CQUINs 2016/17

- Royal Wolverhampton Hospitals NHS Trust

RWHT Value of CQUINs 2016/17		£7,134,305	* awaiting data				
Indicator Number	Indicator Name	Expected Financial Value	Indicator Weightling	Q1	Q2	Q3	Q4 to be finalised
1a	Introduction of staff health & wellbeing initiatives (Option B)	£713,431	10.00%	G			TBC
1b	Healthy food for NHS staff, visitors and patients	£713,431	10.00%				TBC
1c	Improving the uptake of flu vaccinations for frontline clinical staff	£713,431	10.00%				A
2a	Timely identification and treatment for sepsis in emergency department	£356,715	5.00%	G	G	A	TBC*
2b	Timely identification and treatment for sepsis in inpatient settings	£356,715	5.00%	G	G	A	TBC*
4a	Reduction in antibiotic consumption per 1,000 admissions	£570,744	8.00%				TBC*
4b	Empiric review of antibiotic prescriptions	£142,686	2.00%	G	G	G	TBC*
5a	Embedding of Treatment Summary Record into pathway for cancer patients	£499,401	7.00%	G	G	G	G
5b	Embedding of Health and Wellbeing event/sessions into cancer pathway for cancer patients	£499,401	7.00%	G	G	G	G
6a	Friends and Family Test	£356,715	5.00%	G	G	G	TBC
6b	Making the FFT Inclusive	£356,715	5.00%	G	G	G	TBC
7	Frail Older People v0.9	£570,744	8.00%	G	A	G	A
8	Paediatric Asthma	£913,191	12.80%	G	G	G	G
9	Year 2 - Blueteq Prior Approval Process	£370,984	5.20%	G	G	G	G
<b>Total</b>		<b>£7,134,305</b>	<b>100.00%</b>				

- **Black Country Partnership Foundation Trust**

Goal Name	Description	Weighting	Expected Financial Value	Quarter 1	Quarter2	Quarter 3	Quarter 4
National 1a	Staff Health and Wellbeing – Introduction of Health and Wellbeing Initiatives	10%	£71,028		N/A	N/A	TBC
National 1b	Staff Health and Wellbeing – Healthy food for NHS Staff, visitors and patients	10%	£71,028		N/A	N/A	TBC
National 1c	Staff Health Wellbeing – Improving the uptake of flu vaccines for front line staff within providers	10%	£71,028	N/A	N/A	Milestone for full payment 75% uptake, 65% for half payment. Trust achieved 60.4%, therefore milestone not achieved.	N/A
National 3a	Improving Physical Healthcare – Cardio-metabolic assessment and treatment for patients with psychoses	8%	£56,822				TBC
National 3b	Improving Physical Healthcare – Communications with GPs	2%	£14,206	N/A		N/A	N/A
Local 1 - MH	HONOS – Improvement of Outcome Scores	20%	£142,056				TBC
Local 2 – Learning Disability	Positive Behavioural Support	20%	£142,056				TBC
Local 3 – CAMHs	HONOS CA	20%	£142,056				TBC
		100%	£710,278				

NB: Joint CQUIN schedule with SWB CCG. Where table states N/A = no milestone for quarter. Quarter 4 data due to be shared by provider end of April 2017.

**7. CHILDREN'S SAFEGUARDING ANNUAL REPORT**

This report was presented on Tuesday 13<sup>th</sup> June to The Quality and Safety Committee and will be submitted to Governing Body on Tuesday 11<sup>th</sup> July 2017.

**8. ADULT SAFEGUARDING ANNUAL REPORT**

This report was presented on Tuesday 13<sup>th</sup> June to The Quality and Safety Committee and will be submitted to Governing Body on Tuesday 11<sup>th</sup> July 2017.

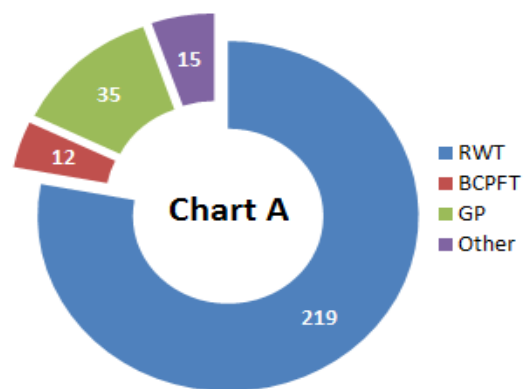
**9. CARE HOMES QUARTERLY REPORT**

This report was presented on Tuesday 9<sup>th</sup> May to The Quality and Safety Committee and will be submitted to Governing Body on Tuesday 11<sup>th</sup> July 2017.

## 10. PATIENT EXPERIENCE

### 10.1 Quality Matters

Quality Matters has once again been well used in 2016/17 with 281 new concerns being closed in the financial year. The number excludes matters that remain open at the time of writing this report which is an additional figure of 40 (321 total). This figure is an increase when compared to previous years; 255 in 2016/16, 220 in 2014/15, 148 in 2013/14 and 100 in 2012-13. **Chart A** displays the overall volume by Provider for 2015-16 *based on closed QIL's at time of reporting*.



The main theme in 2015/16 has been compliance which overall for all providers has slightly risen from 95 to 96 when compared year on year.

As the CCGs main acute provider, The Royal Wolverhampton Trust has received the highest proportion of Quality Matters that have been raised in 2016/17, mainly from GP colleagues (219).

From the 219 closed matters raised in 2016-17, 80 were discharge related making this category the highest from all available for the third year running, with the main highlighted concerns continuing to be either poor quality discharge information, for a period of time draft discharge documentation and poor care / experience in the way in which patients have been discharged from the hospital.

BCPFT has seen an overall decrease in reporting (12) when compared to 2015/16 (15). The concerns that have been raised differ across service specialities and are not specific to one division. Similar to the other main commissioned provider RWT compliance is the leading category for BCPFT.

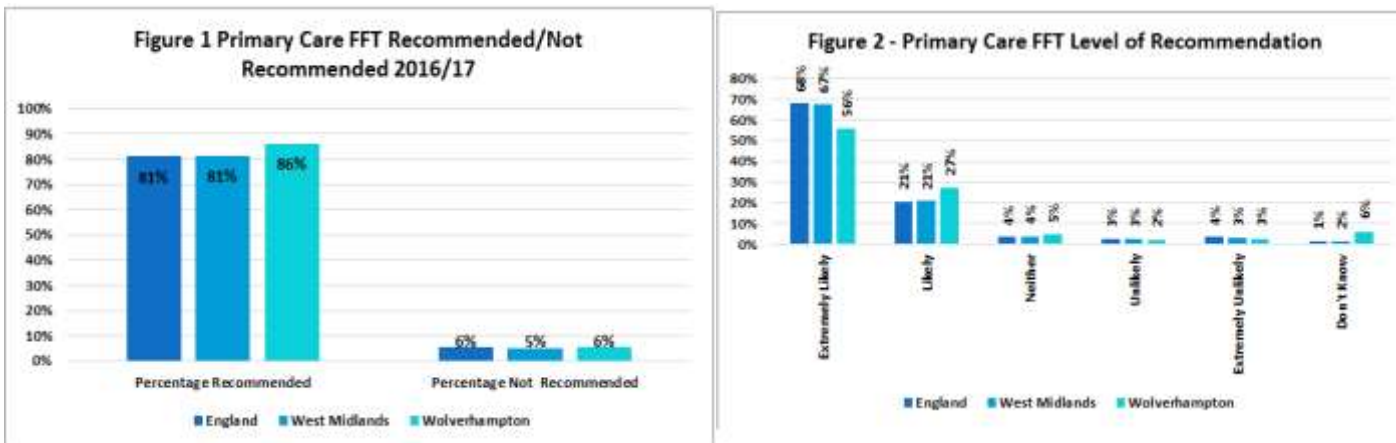
There have been a large amount of individual and collective lessons learned during 2016-17 the most apparent has been larger pieces of service redesign work identified as a result of a large volume of similar Quality Matters, for example „draft discharge“ summaries that were being sent to GP's by The Royal Wolverhampton NHS Trust. The CCG noticed an increase of „draft discharges“ whereby a document was sent to GP's in preparation for discharge however, if the patient then needed to remain an

inpatient the document was still sent with some GPs becoming frustrated they were acting on a request that did not need to happen. After building a strong file of the examples and discussing at CQR, the Trust agreed from 1<sup>st</sup> November 2016 to stop sending the draft discharge documentation. Since this change was made the numbers have significantly reduced with only 1 further example in 2017.

## 10.2 Friends and Family Test

Data is submitted to FFT two months in arrears e.g. in April data for February will be submitted therefore, this includes data submitted between April 2016 (February 2016 figures) and March 2017 (January 2017 figures). Primary care FFT submission has been variable throughout the year. Out of 46 GP practices in the borough on average 7 practices failed to submit any data on a monthly basis (range of 2 to 14 practices). When submissions are lower than 5 this data is suppressed in the NHS England report the average practices with suppressed data was 10 (range of 5 to 18). Submissions are made by a member of GP practice staff via the CQRS tool and results published on the NHS England website where they are accessible to the general public.

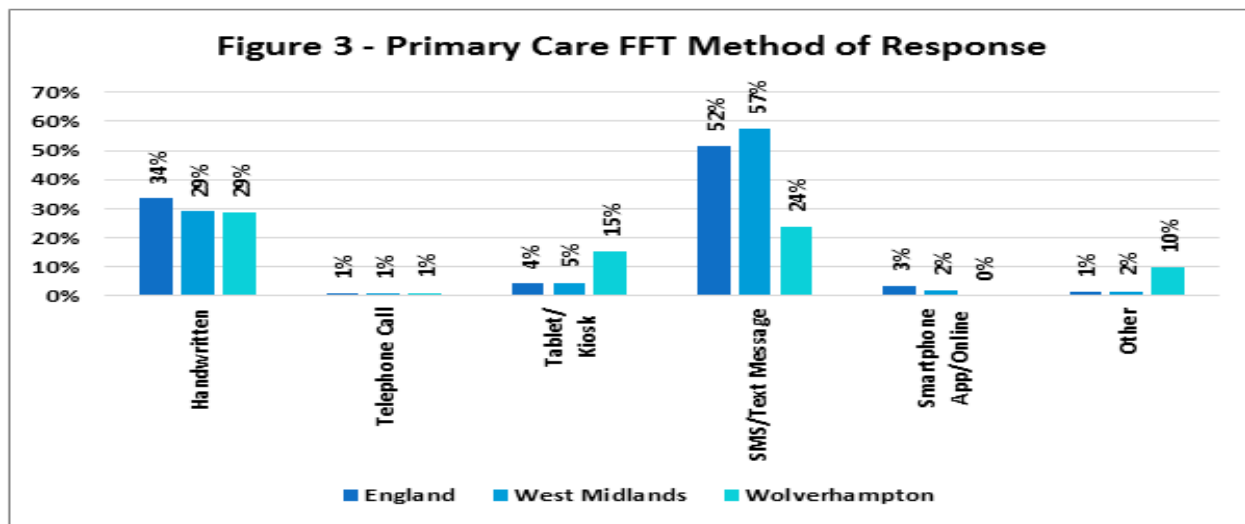
The majority of respondents would recommend their GP practice (86%) and this was higher than both the national and regional average. Those who would not recommend was the same as the national and regional average indicating that 8% of respondents did not answer this question. This is shown below in **Figure 1**.





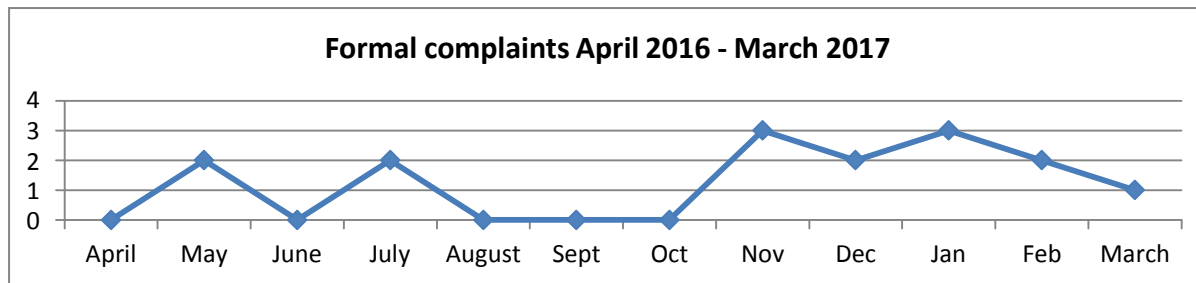
FFT utilises a basic Likert scale to measure recommendation and this is shown in **Figure 2** above. More than half of respondents indicated that they were extremely likely to recommend their GP (57%) and 27% that they were likely. In combination this was 83% which is lower than the national and regional combined average of 89% and 88%. Those that were unlikely or very unlikely to recommend were on a par with national and regional figures however, respondents were more likely to state “neither” or “don’t know”. No qualitative responses are available to offer analysis of themes emerging and this is something that will be addressed in 2017/18 following full delegation. The Primary Care Team is working with the Quality Team to engage with Practices and PPGs to facilitate this.

Methods of response are also measured, nationally and locally the majority of responses are handwritten or via text/SMS (see **Figure 3** below). In Wolverhampton there is a more even balance between written responses (29%), text (24%) and the check-in kiosk (15%). Much of this is down to work undertaken to promote on-line and electronic services in GP practices throughout the city. This is ongoing and the pattern of responses will be monitored over the next year. Other (10%) may relate to verbal responses; however, this is not clear from the NHSE data. There is a cost implication for some methods of collecting FFT data (on-line and text) and this may account for the lower numbers.

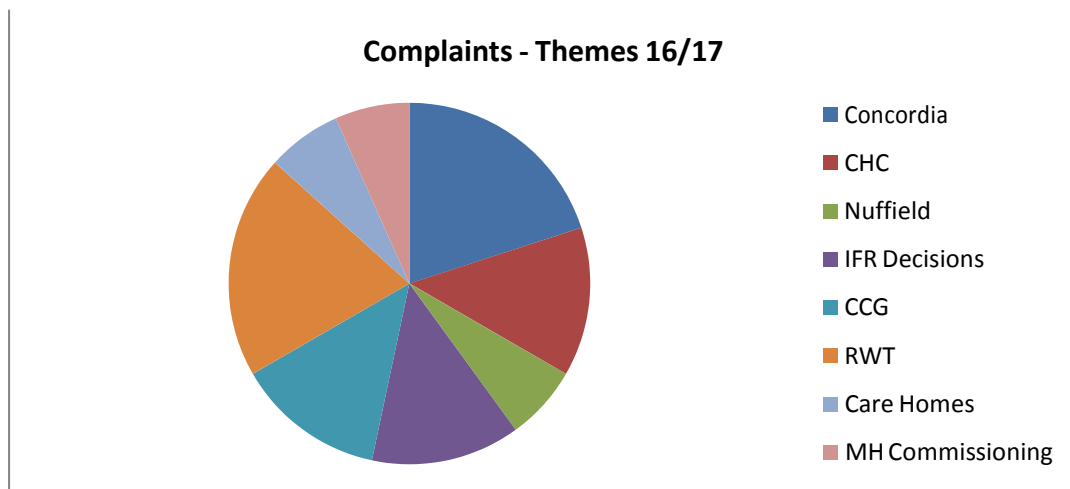


### 10.3 Complaints

There were 15 formal complaints recorded on the CCG register during 2016/17.



These can be broken down as follows:



There are occasional queries raised with the CCG regarding how to make complaints about providers. This information is routinely shared and complainants are supported in making their complaint if they wish.

## 10.4 NICE Assurance

Table A - Audit Presentations based on NICE Guidance				
Audit	Status	NICE Guideline	Priority Area	Presentation at NICE Group.
RWT	Q1	NG19	Diabetic foot problems: prevention and management	May 2016
BCPFT	Q1	TAG77	Guidance on the use of zaleplon, zolpidem and zopiclone for the short-term management of insomnia	May 2016
RWT	Q2	CG60	Otitis media with effusion in under 12s: surgery	Nov 2016
BCPFT	Q2		Not Presented / Escalated	Deferred
RWT	Q3	CG109	Transient loss of consciousness ('blackouts') in over 16s	Nov 2016
BCPFT	Q3	NG46	Controlled drugs: safe use and management	Nov 2016
RWT	Q4	TA238	Tocilizumab	Feb 2017
BCPFT	Q4		Not Presented / Escalated	Deferred

WCCG has a responsibility for commissioning and delivering services that are compliant with NICE guidance and NICE Quality Standards in order to:

- ensure patients and service users receive the best and most appropriate treatment
- ensure the NHS resources are used to provide the most clinically and cost effective treatment
- ensure equity through consistent application of NICE guidance

WCCG has an obligation to demonstrate that NICE guidance is being implemented in the organisations for which it is commissioner. The CCG's NICE Assurance Group focuses on high quality patient care and ensures that all NICE guidance where applicable is embedded in the services it commissions throughout Wolverhampton. The group has specific processes that have been developed to ensure that Providers abide to all National Guidance within timeframe which assures that the best safe effective evidence based care is available.

During 2016/17 the group has changed to meetings on a quarterly basis with themed meetings continuing from 15/16. Audits presented from both the Royal Wolverhampton Hospital Trust and Black Country Partnership NHSFT are shown in **Table A** above.

Within 2016/17 the NICE Assurance group has grown to include other commissioned providers and assurance reports are now sent to the CCG from the following:

Nuffield Healthcare, Heantun (Accord from 1<sup>st</sup> April 2017), Concordia, Vocare and Compton Hospice.

The group will continue to meet on a quarterly basis throughout 2017/18 and the CCG anticipate including further commissioned providers by late 2017/18.

## 11. PRIMARY CARE

### 11.1 GP Practice Visits

From November 2016 to March 2017 Wolverhampton CCG undertook a series of 6 collaborative contracting visits as part of a pilot with NHS England and Wolverhampton City Council Office of Public Health. This programme was designed to furnish the Primary Care Team with the experience needed to undertake contracting visits independently from 1<sup>st</sup> April 2017 in line with full delegation. The following 6 practices received a visit:

Date	Practice
October 2016	Penn Manor Surgery
November 2016	Whitmore Reans Health Centre
December 2016	All Saints and Rosevillas Medical Practice
January 2017	Fordhouses Medical Centre
February 2017	Drs Bilas and Thomas
March 2017	Dr Fowler Practice

Each practice visited was sent a comprehensive template to complete before the visit which included information on the GMS/PMS contract, enhanced services and public health services. Representatives from Primary Care Team, Quality Team, NHS England and Public Health attended each visit and addressed a pre-agreed area of the template. Following each visit an action plan was

agreed where elements of the template could not be completed on the day. Response to the action plans has been variable with some sites responding more quickly than others and there are still some elements that are outstanding.

Visits were generally well received by the practices however, all sites did comment that the number of people attending was intimidating. This issue will be addressed as from April NHS England will no longer be attending and the number of CCG representatives will not be as high now that the process is clearer.

## 11.2 CQC Inspections to GP Practices 2016/17

Site	Report Date	Rating
Parkfields Medical Centre	16/8/16	Good
Prestbury Medical Practice	30/8/16	Good
Warstones Health Centre	30/8/06	Good
Drs Bilas and Thomas	23/9/16	Good
Hill Street Surgery	20/9/16	Good
Bilston Urban Village	19/10/16	Good
Fordhouses Medical Practice	31/10/17	Requires Improvement
Grove Medical Centre	14/11/17	Good
Tudor Medical Centre	14/11/16	Good
Keats Grove Medical Practice	28/12/16	Good
Woden Road Medical Practice	13/1/17	Good
Dr Whitehouse Practice	25/1/17	Good
Duncan Street Primary Care Centre	10/2/17	Good
Penn Manor Surgery	16/2/17	Good
Whitmore Reans Health Centre	17/3/17	Requires Improvement
Thornley Street Surgery	17/3/17	Good
Dr Mittal Practice	25/3/17	Good

Overall ratings were good (88.2%), however there were a number of sites that had requires improvement notices for one or more of the 5 domains measured:

Safe	41.2% (7/17)
Effective	0%
Caring	0%
Responsive	0%
Well-led	23.5% (4/17)

CQC have reported that the majority of practices will be followed up by a desktop exercise as the evidence required is paper-based e.g. certificates or policies. However there are a follow up visits planned where more information is needed, or further concerns were raised. The two practices rated Requires Improvement are being supported by the CCG and NHSE.

This information is discussed at the Primary Care Operational Management Group and is escalated as required. CQC will continue to attend this group following full delegation in April 2017.

## **12. CCG Risk Register**

The Board Assurance Framework and Risk Register have undergone a refresh during 2016/17 following an audit by Price Waterhouse Cooper.

Previously the CCG's BAF was aligned to the four domains set out by NHSE in April 2016 as part of their Improvement and Assessment Framework for CCGs. This proved difficult to manage, as the risks could not be easily aligned, meaning the BAF could not be used effectively by the Governing Body to focus on the CCG's objectives.

Following three Governing Body development sessions held in September, November and March, the CCG's Strategic Aims and Objectives have been refreshed. These have been added to the Datix System and were live as of 1<sup>st</sup> April 2017. The Risk Register has also been refreshed by individual executives. The Risk Register remains a „live“ system and continues to be monitored and managed by executives and risk owners in line with the Risk Management Strategy.

The structures of the risk management reports have been changed to include a summary dashboard. A summary dashboard will be prepared monthly for each Sub-Committee and will become a standing item on Committee agendas.

The Committees that will operationally review the risks are:

- a) Quality and Safety Committee
- b) Finance and Performance Committee
- c) Primary Care Joint Commissioning Committee
- d) Commissioning Committee
- e) Executives (Corporate)

These committees will review their red risks at each meeting, whether new to the register or because the score has increased and review all overdue risks to satisfy itself that the risks are being managed appropriately and in a timely manner. In addition, risks will continue to be reviewed at individual delivery boards.

A staff briefing took place to explain the changes at the Staff Meeting on February. Refresher training was undertaken for all risk handlers during March.

The cleansing of the risk register has reduced the total number of risks due to review of duplicate and outdated risks.

### **13. EQUALITY AND DIVERSITY**

This work is being undertaken and published as part of the CCG's organisational Annual Report.

## 14. RECOMMENDATIONS

The Quality and Safety Committee is requested to:

**14.1** NOTE the contents of this report

**14.2** DISCUSS any aspects of concern and AGREE on actions to be taken

**14.3** AGREE issues to be escalated to Governing Body

**Steven Forsyth**

**Head of Quality and Risk**

30<sup>th</sup> April 2017

### REPORT SIGN-OFF CHECKLIST

	<b>Details/ Name</b>	<b>Date</b>
Clinical View	<b>S Forsyth</b>	<b>30/04/17</b>
Public/ Patient View		
Finance Implications discussed with Finance Team		
Quality Implications discussed with Quality and Risk Team	<b>S Forsyth</b>	<b>30/04/17</b>
Medicines Management Implications discussed with Medicines Management team		
Equality Implications discussed with CSU Equality and Inclusion Service		
Information Governance implications discussed with IG Support Officer		
Legal/ Policy implications discussed with Corporate Operations Manager		
<b>Signed off by Report Owner (Must be completed)</b>	<b>S Forsyth</b>	<b>30/04/17</b>



# Quality Improvement Strategy 2017- 2020



**your health and care matter**

**Quality@the  & Safety@theMind**

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## Statement from the Board

On behalf of Wolverhampton Clinical Commissioning Group we are pleased to introduce the second iteration of our Quality Improvement Strategy which identifies quality improvement priorities for 2017 - 2020. The strategy has been developed in consultation with staff and engagement from our lay members, patient representatives and HealthWatch at our Quality and Safety Committee. The work of the Quality team aims to further progress our ambitions identified within the Clinical Quality Strategy 2015 - 2017; continuing to ensure that our patients receive services that are safe, effective and positively experienced. This work builds on the foundations of our three strategic aims:

- 1. Improving the quality and safety of the services we commission*
- 2. Reducing health inequalities in Wolverhampton*
- 3. System effectiveness delivered within the CCG's financial envelope*

And our local objectives:


- Ensure on-going safety and performance in the system
- Improve and develop Primary Care in Wolverhampton
- Deliver new models of care that support care closer to home and improve management of Long Term Conditions.
- Proactively drive our contribution to the Black Country STP
- Greater integration of health and social care services across Wolverhampton
- Continue to meet our Statutory Duties and responsibilities
- Deliver improvements in the infrastructure for health and social care across Wolverhampton



Dr Helen Hibbs  
Accountable Officer



Manjeet Garcha  
Executive Director of Nursing & Quality



Jim Oatridge OBE  
Interim Chair of the Governing Body



Pat Roberts  
Lay Member for Quality

## Introduction

In our previous version of the Clinical Quality Strategy 2015-2017 we stated that “significant progress has been made in developing the commissioning function, since the Health and Social Care Act 2012, in respect of increasing access to services, value for money and reducing waiting times and greatly improving on infection control targets. As Healthcare commissioners our motto is “quality at the heart and mind of everything we do” this is referencing our patients, our community, families, carers and everyone who requires healthcare from the services we commission in our great City of Wolverhampton.” Our mission statement is

♥ ***“Quality at the heart and Safety at the mind of the Organisation”***

Our focus has remained on assuring patient safety and the quality of services commissioned; engaging the public and improving the patient experience. This remains the same today as it did during its launch in 2015-2017, it is however time to raise our ambitions even higher with the launch of this new reenergised Quality Strategy to reduce unwarranted variation through the work of our Black Country Sustainability Transformation Plan and locally to prioritise the elimination of avoidable harm which includes eliminating avoidable deaths.

It is an exciting time in Quality and we are excited with the changes in Primary Care being more locally managed and the developments in our Promoting Safer Provision of Care for Elderly Residents (PROSPER) and now Safer Provision and Caring Excellence (SPACE) programme.

Our main areas in Quality include:

Safeguarding – Adults and Children including Looked After Children  
Medicines Optimisation (Strategy 2016 – 2018 Version 2.0)  
End of Life Care  
Equality and Inclusion  
Complaints

Quality (Safety, Experience and Effectiveness)  
Improving Quality in Primary Care  
Assuring Quality of Commissioned Services

Wolverhampton CCG is committed to continually improve, drive up quality and ensure that the patient's experience of care and treatment is sought and, heard and that this important information is utilised to improve services. The approach is to work in partnership with patients, public and all service providers whilst ensuring that evidence-based, safe, high quality services are delivered and sustained.

#Qualityattheheartandsafetyatthemindoftheorganisation  
#Q&S@Heart&Mind  
#QualityteaminWolvesCCG  
#yourhealthandcarematter



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Quality & Safety Team: Plan on a Page 2017/2018



Wolverhampton

Clinical Commissioning Group

Mission Statement : Quality at the heart and Safety at the mind of the Organisation

Quality Team Philosophy: Our team is quality driven providing commissioning outcomes that include outstanding care, improving health and lowering service costs, whilst ensuring equality, dignity and respect for all. We will work collaboratively maintaining that patients/service users are at the core of everything we do, in partnership to co-create consistency and seamless care, improving the quality of life for the population of Wolverhampton.

Wolverhampton Clinical Commissioning Group (WCCG) Strategic Objectives

1a. Ensure on-going safety and performance in the system

2a. Improve and develop Primary Care in Wolverhampton

2b. Deliver new models of care that support care closer to home and improve management of Long Term Conditions.

3a. Proactively drive our contribution to the Black Country STP

3b. Greater integration of health and social care services across Wolverhampton

3c. Continue to meet our Statutory Duties and responsibilities

3d. Deliver improvements in the infrastructure for health and care across Wolverhampton

Safeguarding Vulnerable Adults & Children/Looked After Children	Primary Care	Residential/Nursing Homes & End of life Care	Quality & Risk Team	Equality & Inclusion	Medicine Optimisation Team
<ul style="list-style-type: none"> <li>WCCG ensure that they secure the expertise of a named GP for safeguarding adults, this is an essential role due to the delegated primary care commissioning arrangements.</li> <li>Effective project management for NHSE allocated funding for Mental Capacity Act (MCA) and collaborative commissioning of continuation of the MCA project with other CCG's to include practitioners working with young people (16-18 year old).</li> <li>Deliver key messages across our community regarding the voice of the child, think family and making safeguarding personal, commissioning specialist drama group to provide bespoke training</li> <li>To progress commissioning outcomes, training, operational exposure and ensure all providers arrangements regarding prevent are robust.</li> <li>To work with partner services to develop processes that differentiates between safety, safeguarding and quality.</li> <li>To collaborate with multi agency colleagues to develop best practice adult safeguarding guidance for providers of healthcare in Wolverhampton, in order to eliminate confusion between safeguarding, safety and being safe.</li> <li>That LAC placed out of City receive the same quality of health care as those placed internally.</li> <li>Work with CCG Children's Commissioner to provide a reporting mechanism on the quality assurance measures relating to therapeutic placement providers for Looked After Children.</li> </ul>	<ul style="list-style-type: none"> <li>Supporting the Primary Care Team in the CCG to develop the quality outcomes framework GP contract to ensure it reflects the health needs of the people of Wolverhampton.</li> <li>Working with Public Health, GPs and the wider health economy to develop preventative health strategies</li> <li>Working with the CCG Primary Care Team to ensure that full delegation is effective and quality remains at the forefront .</li> <li>Developing the workforce to help increase numbers of staff and training opportunities for nurses, GPs and non-clinical staff to make primary care an attractive career progression.</li> <li>Developing a one stop shop for health and social care, working with the Better Care Fund team and the Community Hubs to promote social prescribing and signposting people to improve and maintain their health and well being.</li> </ul>	<ul style="list-style-type: none"> <li>Increased reporting of incidents, near misses and lessons learnt leading to a reduction in harms across the sector.</li> <li>Achieving and delivering on the milestone of Safer Provision and Care Excellence (SPACE)</li> <li>Driving up quality of care and safety culture through positive reporting and effective management of incidents leading to fewer serious incidents due to embedded learning.</li> <li>Influencing the delivery of commissioning strategies such as care closer to home and admission avoidance agendas by supporting the development of care managers to build resilience across the care home sector.</li> <li>Facilitate the use of advanced care plans with patients at the end of their Life.</li> </ul>	<ul style="list-style-type: none"> <li>Embed the new Serious Incident contract regulations to ensure timely submissions.</li> <li>NICE for all Providers.</li> <li>Take forward Quality visitable top reviews.</li> <li>Sharing our learning on Serious Incidents &amp; Root Cause Analysis and to remain as outstanding CCG.</li> <li>Integrated Quality visits e.g. Healthwatch &amp; patient reviewers engagement.</li> <li>Develop new Serious Incident recording process (pilot &amp; test).</li> <li>Embed Serious Incident Scrutiny Group with providers attendance.</li> </ul>	<ul style="list-style-type: none"> <li>Supporting the CCG to gain assurance from providers on their Equality Diversity Inclusion and Human rights (EIHR) compliance.</li> <li>Embed Equality Diversity System2 (EDS2) in CCG business practice.</li> <li>Update the Equality &amp; Diversity Strategy and Policy For 2017 – 2020.</li> <li>Refresh and embed equality objectives in CCG business practice.</li> <li>Support the CCG to be a system leader of Workforce Race Equality Standard (WRES)</li> <li>Provide expert advice and support to CCG decision makers through Equality Analysis (EA's)</li> </ul>	<ul style="list-style-type: none"> <li>Re-procurement of GP Prescribing Support.</li> <li>Right Care.</li> <li>Quality, Innovation, Productivity and Prevention (QIPP)</li> <li>Working with Regional Medicines Optimisation Committee.</li> <li>Safer Prescribing of drink thickeners.</li> <li>Cost effective respiratory prescribing.</li> <li>Support for health economy Anti-Microbial Resistance program.</li> <li>Increasing uptake of biosimilars.</li> </ul>

Patient Reviewers and Representatives are involved and inclusive as an integral part of the Quality Team

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**Our Aim**

**Our Quality Objectives**

**Success Measures**

<b>Effectiveness</b>	<b>Safety</b>	<b>Patient experience</b>
<p>A commissioning and procurement process that actively involves members of the quality team.</p> <p>A highly skilled patient safety, quality and risk team that is capable of delivering our quality objectives and which demonstrates co creation, cohesiveness and a strong team dynamic.</p> <p>Reduction in Remedial Action Plans due to organisations learning the lessons and promoting innovation as opposed to reactive services.</p> <p>Reducing unnecessary duplication and unwarranted clinical variation for our patients and service users.</p>	<p>A reduction in the number of Hospital Acquired Infections occurring within the community and provider organisations.</p> <p>A health economy wide reduction in Pressure Injuries.</p> <p>Building on our foundations that safeguarding is considered as everyone’s business.</p> <p>Develop a stronger relationship with our GP practices that encourages a culture of reporting and openness of incidents from Quality Matters to Serious Incidents.</p> <p>A reduction in Serious Incidents and Never Events with common themes.</p>	<p>We will ensure the continued use of high quality healthcare providers.</p> <p>That enable high levels of patient satisfaction from patients’ experience.</p> <p>Fewer complaints with common themes.</p> <p>Patient feedback through patient stories, working with our patient reviewers and patient representatives to influence and shape continuous improvement in the safety and quality of care of we commission.</p> <p>Continuous quality improvement measured through surveys and contract KPI’s</p> <p>Local service users check local services as their preferred choice of care delivery</p>

**Our key achievements in 2016/17**

Increased rigour and developing our internal framework to Serious Incident Management  
 Outstanding rating as a CCG  
 Patient Safety Award – Molly Henriques-Dillon (Quality Nurse Manager)  
 Shortlisted for HSJ Patient Safety of the Year Award 2017  
 Sign upto Safety – (Appendix 1)

## What we Commission

We commission services from a range of providers; both NHS and Independent Sector and we act as lead commissioners on behalf of CCGs for our main Acute Provider. The public has a right to choose treatment and care in the NHS and the choice of care and provider should be offered, depending on what is available locally.

An extensive list of contracts is held by the CCG and available from the Contracts Team. Our two main providers are:

Royal Wolverhampton Trust <http://www.royalwolverhampton.nhs.uk/>

Black Country Partnership Foundation Trust <http://www.bcpft.nhs.uk/>

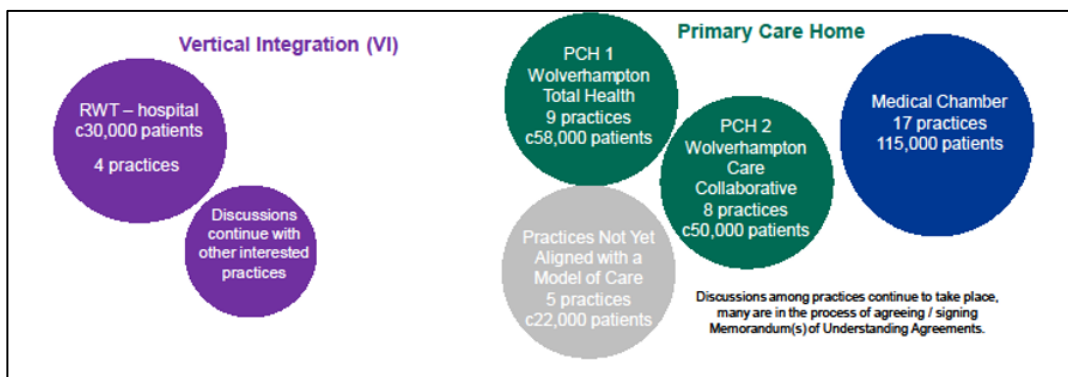
From the 1<sup>st</sup> April 2017 NHSE will handover Primary Care as part of 'full delegation.

The Quality & Risk Team actively support the development and review of service specifications and seek to ensure that once awarded, contracts are monitored routinely in line with the terms and conditions defined within the NHS contract.

## Primary Care

### New Models of Care

Wolverhampton practices are currently evolving into Primary Care Home Model and Vertical Integration with Royal Wolverhampton Hospitals Trust. The aim is to work collaboratively to address the challenges in primary care through improving access to services and optimising health. Governance will be provided via peer review, NICE Quality Standards, Information Management and Technology (IM&T) and Quality Assurance monitoring. The current model is shown below: *(this is subject to change)*



This model will continue to develop as the final groups align. More information about new models of care is available via [NHS England](http://www.nhs.uk).



## Improving Quality Primary Medical Services

The CCG currently has a statutory duty to assist and support NHS England Area Team in securing continuous improvement in the quality of primary medical services and will therefore ensure that the core principles of NHS England Primary Medical Care are adopted locally through established lines of communication and joint working. This process will continue following full delegation with the CCG taking on more responsibilities within a Memorandum of Understanding with NHS England.

- To promote and prioritise equality including access and treatment for all patients across the full range of primary medical services and new models of care
- To focus on quality, outcomes and relevant patient experience as the main drivers for Improvement
- Primary care commissioning arrangements & plans
- To determine health outcomes
- To promote a clinically driven system in which GPs and other primary medical service clinicians are at the heart of the decision making process, driving quality improvement and commissioning decisions
- To facilitate strong and productive local contractor relationships based on proportionate and sensitive interaction
- Be responsive to and spread innovation
- To deliver a consistent national framework, which ensures fair and transparent interventions, implemented locally, with local discretion rooted in cultural and behavioural consistency
- Make commissioning decisions on the basis of firm data shared with CCGs, health and wellbeing boards and others and complimented by local intelligence
- To design systems that are fit for the future, allowing reform and operate within minimum bureaucracy. Such systems enable whole person patient care, with integrated physical, mental and behavioural services and facilitate shared best practice standards between primary care and specialists.
- To promote early engagement and collaboration with Local Medical Committees (LMC's) openly and transparently in the management of primary medical services

The CCG (with initial collaboration with the NHSE Area Team) will agree standards and quality indicators in service specifications in relation to Local Improvement Schemes and Directly Enhanced Services, where applicable. Review of clinical audits and quality assurance of performance data will determine the future delivery of services and provide continuous quality improvement.

Delivery of effective, safe and high quality primary medical services will require the CCG to play an active role in exercising its statutory responsibilities for member practices within its area once fully delegated. The CCG are already responsible and accountable for services commissioned locally through the standard NHS Contract i.e. Enhanced Services. A schedule of collaborative contracting visits with representation from the CCG Quality Team, Primary Care Team and Public Health is underway to provide assurance around contracting and quality requirements within general practice.

Additional support will be provided for practices via NHS England incentives such as Vulnerable Practices and Practice Resilience Programmes delivered by Primary Care Support England and the GP Development Programme as part of the [GP Forward View](#). Work is also being undertaken collaboratively with other CCGs in the Black Country to develop the estates and IT infrastructure as part of the Sustainable Transformation Plan.

### **Primary Care Operational Management Group (PCOMG)**

The current purpose of this group is to maintain an overview of and direct the work of Wolverhampton CCG with regards to Primary Care Commissioning following full delegation in April 17. This supports the work of Primary Care Commissioning Committee (PCCC),

The PCCC committee supports and acts upon information they are furnished with following these meetings and where necessary take on items requiring furtherance and in exceptional circumstances matters of concern will be raised with the CCG Executive Team. The PCOMG also supports the reporting to the Quality and Safety, Finance and Performance or Commissioning Committees on any issues that arise that fall within the purview of these committees. The Primary Care Quality Assurance Coordinator is be responsible for providing routine quality reports on activity in primary care to the committee as part of the overall Quality and Safety Report.

Meetings are held on a monthly basis and receive appropriate administrative support to ensure that a schedule of meetings is shared in advance for the respective year, a suitable venue is arranged and meeting papers are distributed at least one week prior to each meeting using the standard agenda as a minimum. Formal minutes and a corresponding action log are produced following each meeting and distributed to group members within 3 weeks of the meeting date.

### **Primary Care Workforce Development**

In line with the national picture, a number of issues pertinent to primary care workforce in the City have been identified:

- Lack of General Practice Nurses and GPs
- Ageing workforce
- Retirements
- Lack of succession planning

A local Workforce Task and Finish Group are cited in the CCG governance structure and an attached workforce implementation plan with range of activities detailed within this programme of work, this comprises of four main areas:

- Attraction

  - Workforce Scoping & Planning  
Wolverhampton - A Place to Work

- Recruitment

  - Pilot mapping skills for new primary care service provision models

- Development

  - Develop a primary care workforce development strategy  
Career Development for clinical and non-clinical staff  
Piloting new roles/new ways of working  
Developing a leadership culture within primary care  
Improving and implementing standards of practice  
Increase training capacity in primary care

- Retention

Local work will continue around practice nurse development in line with Health Education England GP Nurse Development Plan. The plan identifies a number of key areas that are aligned with the workforce implementation plan:

- Increasing the profile of General Practice Nurses (GPN's) to pre-registration students
- Increasing recruitment of newly qualified nurses to general practice by providing robust support
- Promoting professional development
- Standardisation of job descriptions
- Promoting non-medical prescribing
- Optimising the use of Advanced Nurse Practitioners (ANP's)
- Return to practice for GPN's
- Leadership skills (clinical and non-clinical)
- Promoting the development of support staff e.g. health care assistants and nursing associates
- Development of nursing apprenticeships

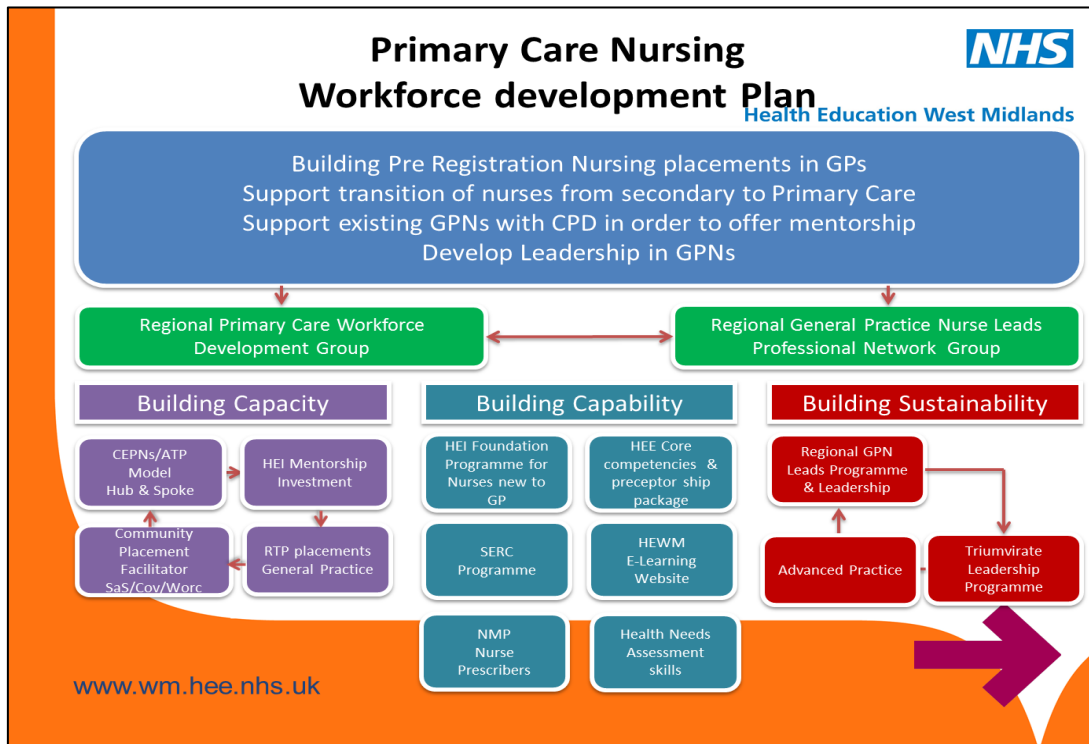
Funding support for the development of existing General Practice Nurses is released via HEE to local Community Education Provider Networks (CEPNs). CEPNs are independent bodies, currently funded by HEE who are responsible for local workforce planning and distribution of funding. Wolverhampton CCG is currently aligned to Walsall CEPN and works closely with the CEPN Project Manager to identify training needs and ensure appropriate and timely allocation of funds.

In addition to this alternative roles to support General Practices are:

- Physicians Associates
- Clinical Pharmacists
- Mental health therapists
- Paramedics

These will also be promoted in conjunction with Health Education England (HEE).

Representation from both the CCG and GPNs is in place at regional level, local arrangements were introduced during the summer of 2014 to manage the agenda and clinical skills development in Wolverhampton. The Primary Care Quality Assurance Coordinator continues to work with the Executive Nurse to monitor and develop this.



Wolverhampton CCG continues to work in collaboration with local Higher Education Institutes, Health Education West Midlands and NHS England to ensure that key priorities are met, as identified above.

In addition to this work, focus will also shift towards supporting recruitment and development of General Practitioners within Wolverhampton, this is supported by HEE and HEWM and the West Midlands Deanery. The concerns around GP workforce reflect those of GPNs, lack of numbers, aging workforce and difficulties in recruitment and retention of staff; coupled with high numbers of GPs opting to work as locums. Workforce implementation planning aims to increase numbers of partners and salaried GPs and support GP training.

The General Practice Forward View will also offer development opportunities for administrative staff via Care Navigator and Medical Assistant training. In addition to this practice manager development will also be offered as part of the overall GPFV. Leadership opportunities for all practice staff can be accessed through the [Triumvirate Leadership Programme](#) via HEE, and through the [NHS Leadership Academy](#). Support for recruitment, development and retention of both clinical and non-clinical staff will also be provided by the GPFV.

## Care Homes Sector

People living in residential and nursing homes should receive high quality compassionate care, expect to be treated with dignity and respect and protected from harm. Systems should be in place that identifies those people at risk and care will be tailored to individuals' needs and preferences. Care should be based on the best evidence and practice, centered on the person, supported by good governance and accurate record keeping. Staff working in the care home sector have a duty to ensure they have the appropriate level of knowledge and skills to deliver and promotes high standards of care and have the ability to respond to the complex and changing needs of the residents.

The Care Home improvement Plan implementation across the care home sector will be led by the Quality Nurse Advisor (QNA) team on behalf of the CCG. Through a programme of scheduled quality and sustained improvement visits the QNAs will be pivotal to monitoring, facilitating improvements and providing assurance to the Board of the quality of care delivered by commissioned services. Priority of quality visits will be determined on whether the Provider has health funded beds e.g. step down and/or whether quality concerns have been raised. Care homes with AQP and NHS contracts will be expected to participate in the quality framework by way of submitting monthly self-assessment quality indicator returns and subscribing to the Safety Thermometer data collection. Care homes not in the commissioning framework will also be encouraged to participate. Implementing best practice guidelines and promoting best practice in care homes will be the vehicle for navigating quality standards across the sector and standardising practice.

The SPACE (Safer Provision and Care Excellence) programme aims to drive up quality and safety culture through training and promoting the use of quality improvement tools and techniques. The QNAs in collaboration with the Local Authority will support the safeguarding agenda through involvement of section 42 enquires and quality concerns investigations in line with the Care Act 2014. The sharing of lessons learned and development of action plans will accelerate progress with care home managers achieving high quality harm free care for residents. The QNA team will promote positive reporting across the sector to achieve a culture learning from excellence and sharing of best practice.

Performance against the harm free care target of 95% will be monitored by the QNA team and under performance will trigger closer scrutiny and involvement by the team. Robust communication between the CCG, Wolverhampton City Council, MASH (Multi Agency Safeguarding Hub), health and the regulators will enable better partnership working and joint working towards achieving harm free care across the city.

### **End of Life Care and Cancer Agenda - Macmillan Primary Care Nurse Facilitator (MPCNF)**

This is an innovative new post, supported by Macmillan, full time contract for a fixed term of 3 years, due to be reviewed in May 2019. WCCG and MPCNF will support primary care teams with respect to the Primary Care Strategy, Workforce Development and implementation Plan, incorporating the cancer agenda, specifically focusing on End of Life Care (EoLC), Cancer Awareness /Prevention, Early Diagnosis and enabling patients to live with alignment as a long term condition (where possible), promoting optimal outcomes for patients thus promoting the Macmillan Survivorship Agenda within Wolverhampton.

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

### **End of Life Care**

WCCG has developed new EoLC Strategy in collaboration with RWT, Compton, LA, Voluntary sector, this is a large body of work and the aim of this strategy is to detail Wolverhampton's integrated approach to the design and delivery of a person centred, integrated, end to end-End of Life care service.

To deliver a flexible, responsive, quality service to those approaching the end of their lives. The strategy will encompass the following elements:

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

There are large programmes of work currently underway in relation to different elements of the EOL strategy namely, ACP (Advance Care Plan), EPaCCS, (Electronic Palliative Care Coordination System) Early identification of end stage disease, Education & Training with regard to Communication in Palliative Care, and Patient and User engagement. This work is ongoing alongside the ratification and publication of the Strategy and timeline.

There is continuing CCG engagement with Service User and Stakeholder representatives to understand what local people want from local End of Life and Palliative care services. The CCG hold several patient and user focus groups, including market place stalls at local Carer information sharing events.

The CCG and the MPCNF have developed an education and training need assessments across secondary and primary / community care, with engagement with local specialist palliative care providers of education to deliver relevant, tailor-made training packages which will address the needs identified in secondary, primary / community care. Acknowledging the need for place based learning, peer review and peer support, and an option to explore external facilitation of training & support.

WCCG has developed links with HEE (Health Education England) and local Hospice Association to explore options for support in educational sessions, Education and Training – (with links to the SPACE project) and Nursing Home education and training. As well as successful attainment of a Macmillan Funding bid to assist with Education and Training package, for the End of Life Strategy programme.

Encompassing in the roll out an ACP (Advance Care Plan) PILOT with local Nursing and Residential homes. Due for completion in May 2017.

### **Survivorship Agenda - The Recovery Package**

National Cancer Survivorship Initiative(NCSI) were set up in 2008 to address these challenges, its aims to ensure that those patients living with and beyond cancer get the care and support they need to led as healthy and active a life as possible, for as long as possible. Current Survivorship programme in Wolverhampton, involves the CCG working with the Cancer Leads within Royal Wolverhampton Hospital Trust (RWT), RWT currently have secured a CQUIN to provide H&WB (Health and Well Being) for breast care patients only. RWT are continuing to actively improve uptake of this service, by changing the model to engage with a larger cohort of patients.

H&WB Events / sessions should be offered to patients once they have completed initial treatment and include information on healthy lifestyle choices including physical health and healthy weight management, sign and symptoms of recurrence and potential consequences of treatment, and initially it was believed that to hold an annual Market Place Event, would be the preferred choice, and this model is currently due to be rolled out in June 2017.

WCCG hold regular consultation meetings with Cancer Leads at RWT and Cancer Peer Review team, reviewing service and progress on 31/62 day target and breaches, referral processes and appropriateness of GP Fast track referrals, and potential bottle necks in the systems that cause delay in the cancer pathway.

Also WCCG have completed review visits with Quality Team at RWT for the Oncology service.

### **Cancer Prevention, Early Diagnosis**

WCCG and MPCNF have engaged with RWT, (the Bowel Cancer Screening Health Promotion Team) and CRUK to facilitate improvements on how locally Wolverhampton can improve the uptake for screening programmes, specifically the bowel screening uptake, breast screening and Ovarian screening.

WCCG in collaboration with PH, are committed to raising cancer awareness, by facilitating

Cancer awareness /promotion events – unmanned stands/ stalls for Breast awareness month October, and Pancreatic and Lung Cancer awareness in November. Literature, information and flyers and resources available during those months to highlight “Symptoms and what to look out for”

## Working in Partnership

We currently commission Continuing Health Care(CHC) services within the CCG to arrange packages of CHC, funded nursing care and after-care from a range of providers. These include nursing homes, domiciliary care and supported living. Patients can have access to Personal Health Budgets and working with the Local Authority we monitor the quality of these providers and manage the market as both organisations (CCG and Local Authority) commission similar services.

The CCG also commissions services for people who have an Individual Funding Request approved, this is where people require a bespoke clinical service that is either rarely required, (or thus not regularly commissioned) or relates to exceptional circumstances. This is via Commissioning Support Unit for adults and directly by the CCG for children and young people under 18 and those adults with complex Mental Health needs leaving secure care settings.

Furthermore, the CCG recognises that it cannot achieve these objectives working in isolation and in order to secure the necessary improvements we will work closely with partner agencies both at local and national level.

**Our relationships include the following organisations** (this is not a complete list)

<https://improvement.nhs.uk/>

<https://www.england.nhs.uk/>

<http://www.healthwatch.co.uk/>

<https://www.gov.uk/government/organisations/public-health-england>

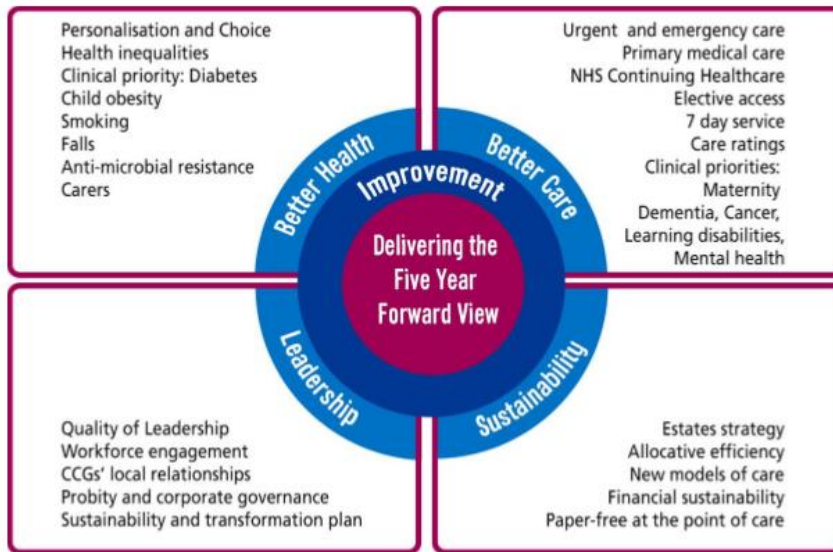
<http://www.wolverhampton.gov.uk/home>

<https://hee.nhs.uk/hee-your-area/west-midlands>



## Quality Improvement & Assurance

In order to improve quality in the NHS we have to be sighted on the needs and challenges presented both nationally and locally, the NHS Outcomes Framework enables us to achieve an overview that make up the outcomes framework and whilst they are designed to support commissioners in developing localised plans and establishing their levels of ambition ultimately quality improvement is the golden thread that should flow throughout the work of the CCG.

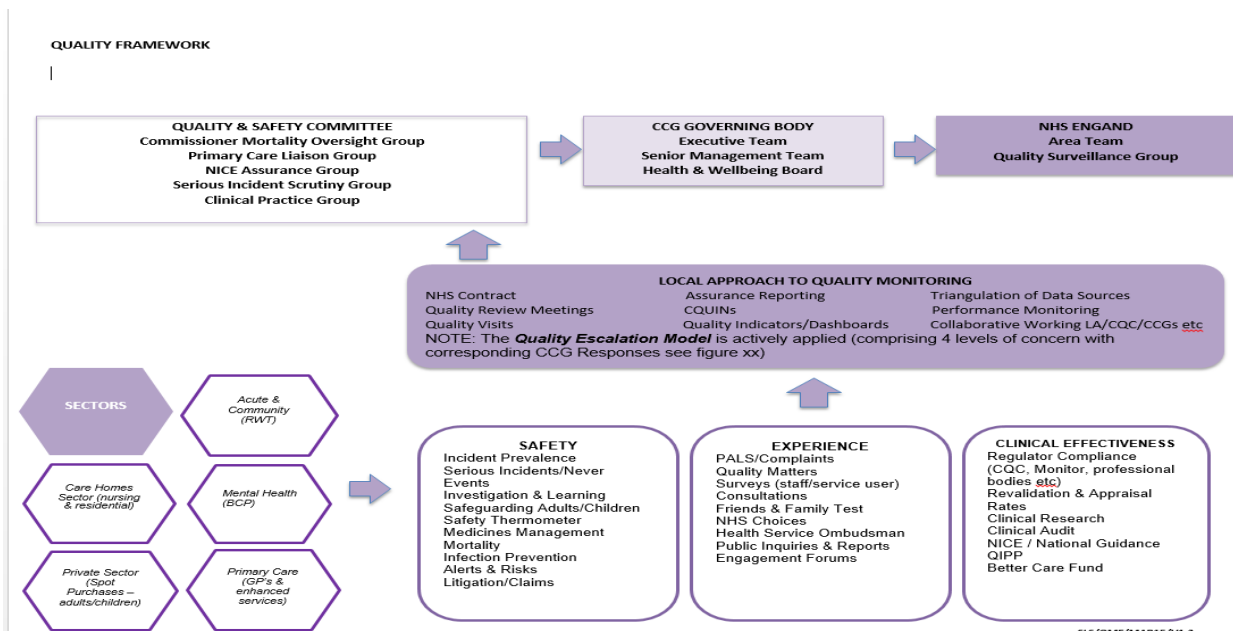


At national level there are many sources of guidance that have been developed and shared that help health care organisations to prioritise and align themselves with a vast array of priorities and areas of importance, some of those documents and initiatives are detailed below:-

## Quality Framework

Our framework for monitoring quality demonstrates how we monitor clinical quality across all sectors where we have a responsibility or duty in accordance with the Health and Social Care Act 2012 and the NHS Constitution that clearly advocates the rights and pledges of staff working in the NHS and those patients receiving care. Each of the sectors we are responsible for are clearly defined and reliant upon a consistent focus on the three domains of clinical quality i.e. safety, experience and effectiveness as first set out by *Lord Darzi\* in the NHS Next Stage Review (2008)* placing quality at the heart of everything the NHS does and emphasises the patients right to high quality care.

The framework is built upon the plethora of intelligence available to us about our providers and enables us to work closely with our providers through our local approach to quality monitoring that is underpinned by a contractual relationship that promotes mutual respect among peers and commitment to quality improvement.



We are responsible for the following:

- Monitoring delivery of standards and quality through the commissioning process
- A duty to require and monitor delivery of fundamental standards
- Ensuring there are resources to enable proper scrutiny of our providers' services, based on sound commissioning contracts
- Ensuring assessment and enforcement of fundamental standards through contracts and the development of alternative sources of provision if necessary.

\* High Quality Care For All: Next Stage Review Final Report (NSR), which was led by Lord Darzi and published on 30 June 2008.  
<https://www.gov.uk/government/publications/high-quality-care-for-all-nhs-next-stage-review-final-report>

## Quality in the Commissioning Cycle

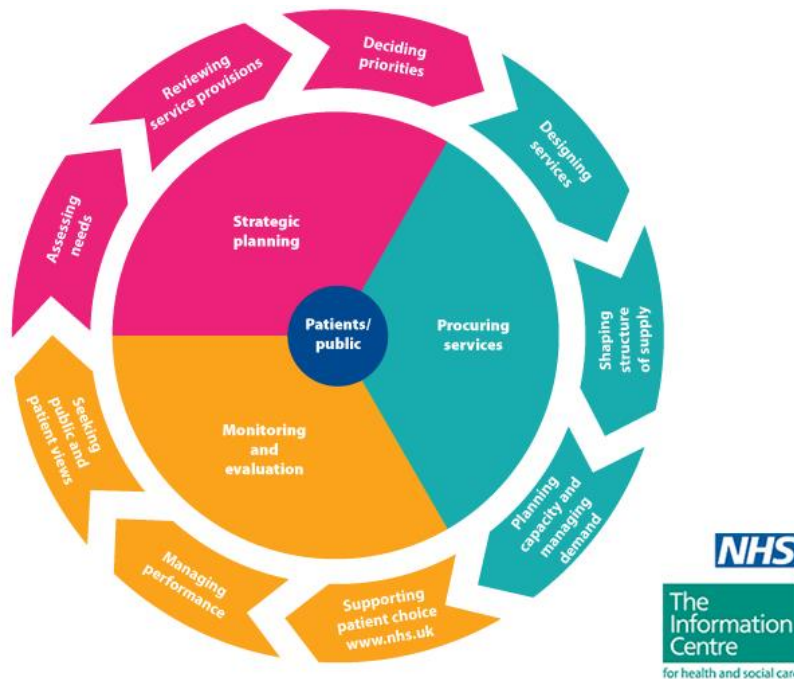
High Quality care is defined in three equally important parts



**The Three Dimensions of Quality**

1. Clinical effectiveness, where high quality care is evidence based care
2. Safety, where high quality care is care delivered in a safe environment
3. Patient experience, where high quality care gives someone as positive an experience of treatment and recovery as possible including acknowledging people's wants or needs, and treating them with compassion, dignity and respect

The process for considering quality in the commissioning cycle is pictured below and demonstrates how we embed quality throughout our organisation and is dependent upon the identification and development of quality metrics incorporated into our planning and commissioning processes.



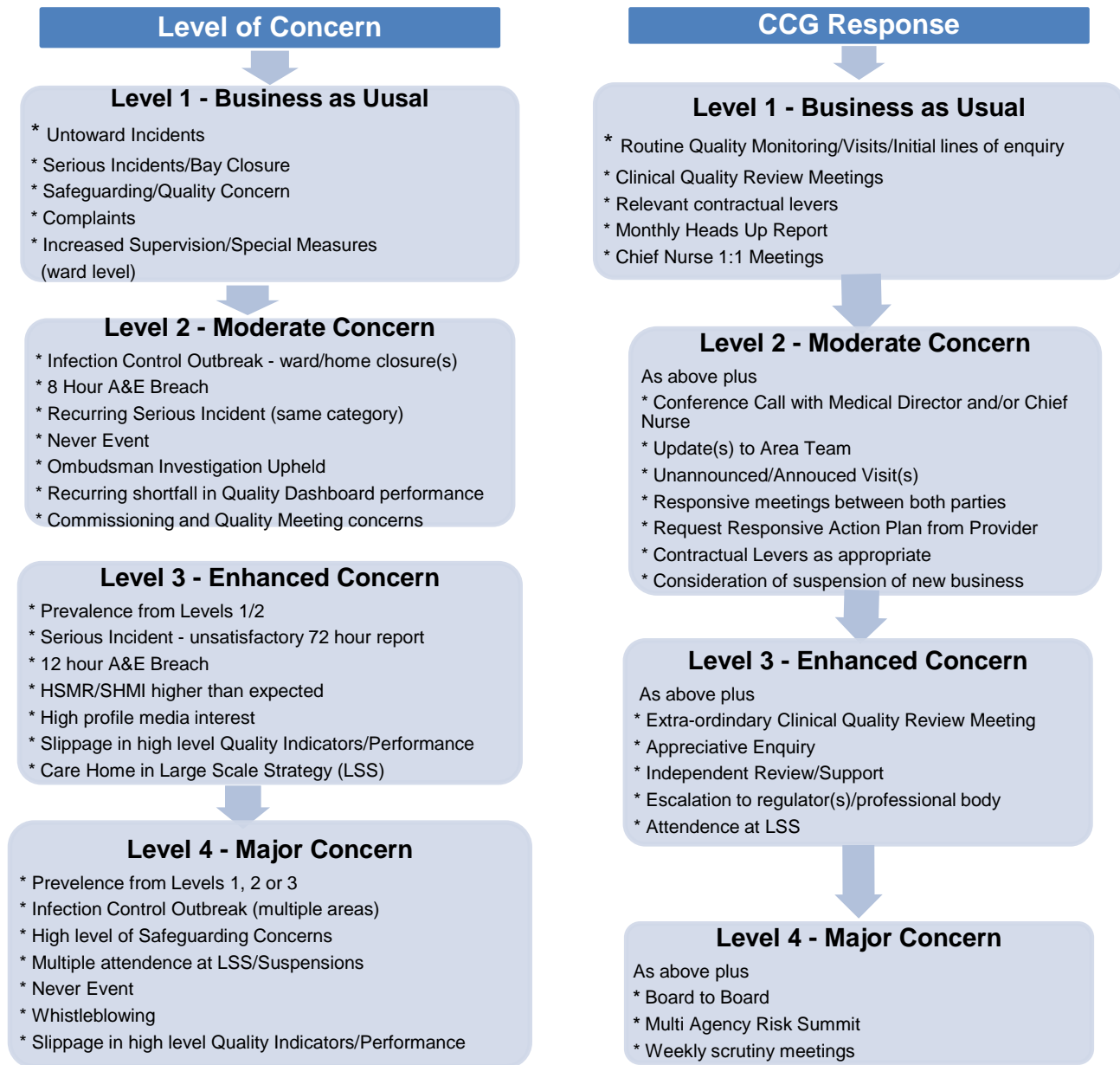
We work in partnership with providers whilst ensuring that evidence-based, safe, high quality services are delivered. Locally we continue to develop and improve the ways in which we are monitoring patient quality, safety, experience and the effectiveness of our service providers.

Assurance reporting based on our joint working with our providers through application of the NHS contract is reflected on a monthly basis via our Quality Assurance Report that is considered by the Quality & Safety Committee. The committee seeks to be assured that the framework is being applied with rigour, responsibilities are being fully realised and that the framework is being utilised to assist our providers to meet the demands of the high standard we want and need to achieve.

### Escalation Model

Measurement of quality is achieved through correlation with the Quality Framework that seeks to ensure high standards of quality are sustained. However, there are occasions when circumstances change and providers will be challenged so that the CCG is assured of the robustness of quality information being afforded and the effectiveness of compensatory actions and control measures that have been put in place to address the exposed concern(s).

The escalation model defines four levels of concern that may arise and the corresponding actions that will be applied to seek assurance that circumstantial change has been appropriately managed and appropriate control measures have been put in place in response to the level of concern.



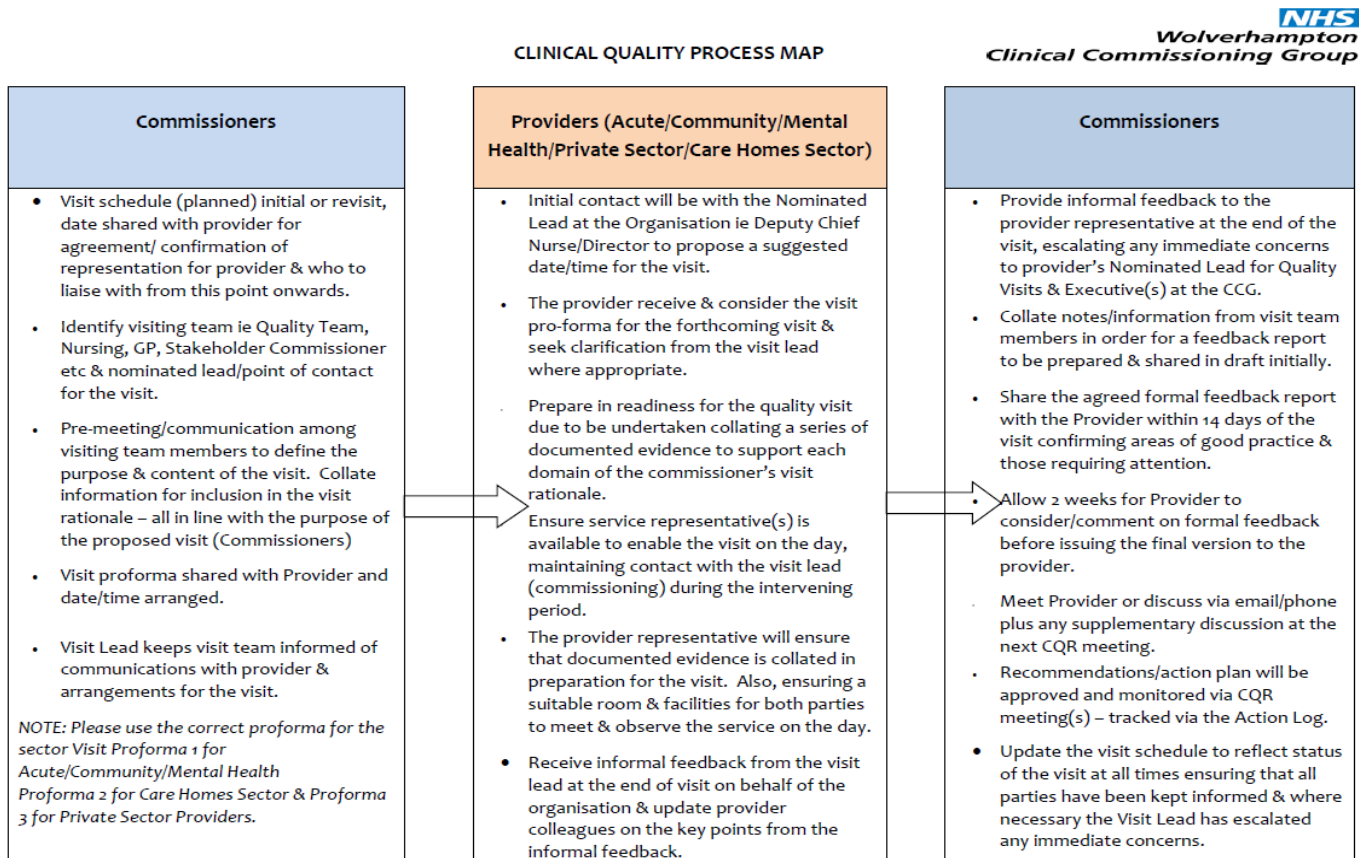
At operational level the escalation model will be assigned to each of the CCGs commissioned providers reflecting the level of concern and corresponding level of response that has been applied and will be reflected in assurance reports provided to the Quality & Safety Committee. It is important to note that the application of the model is underpinned by a collaborative approach to managing concerns pertaining to clinical quality that may be driven by activity and performance that constitutes concern about the quality of care patients may be receiving. A co-ordinated approach among teams within the CCG will be deployed to prevent replication and inconsistency of understanding and communication with the provider.

## Quality Visits

There are many benefits attached to commissioners strengthening relations with their providers through visiting services to gain a greater understanding and where necessary assurance about commissioned services.

A program of planned visits is agreed with each provider. However, if there are any areas of concern, or a wish to focus on a topical issue for assurance, an unannounced visit will be undertaken.

These visits will be undertaken across each sector throughout the contract year – the number/frequency of visits will be determined by the number of services commissioned/contract value/level of concern using the following communication process:-



Each visit will be complimented by a suitably populated visit rationale using the CCGs visit pro-forma and will be used to document the findings from the visit. Visiting teams will comprise of staff members from the quality team, trained patient reviewers and Healthwatch who will make observations, review documentation and where appropriate have discussions with staff and seek patient views.

Where deemed necessary an action plan will be developed if gaps, risks and areas where room for improvement have been identified. This will be routinely monitored until timely completion via the respective Quality Review Meeting or appropriate forum.

In the previous Clinical Quality Strategy we wanted to move forward, towards the recruitment and training of Patient Representatives to become reviewers and will accompany WCCG visiting teams in the future. We are pleased to confirm this recruitment has been achieved of patient reviewers and they will play a big part in our quality visits for this 2017 – 2020 Quality Improvement Strategy.

## Quality Systems & Processes

There are many areas detailed within our framework that highlight the many areas of clinical quality that are invested in within the CCG. In this area of the strategy those areas are broken down to provide an overview of what they are and their content. Each area will have its own corresponding policy or procedure that should be read in conjunction with the information provided in this section.

## Serious Incidents

In broad terms, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare. Serious incidents therefore require investigation in order to identify the factors that contributed towards the incident occurring and the fundamental issues (or root causes) that underpinned these and trigger actions that will prevent them from happening again.

There is no definitive list of events/incidents that constitute a serious incident but Serious Incident Framework (2015) has identified 34 categories of serious incidents which include a "pending review" category. However, a category must be selected before incident is closed.

All providers are expected that they report all serious incidents to the commissioners without delay and no later than 2 working days and all serious incident investigation reports are submitted to the commissioners within the contractually agreed timeframe. However, if required depending on the seriousness of the incident, the provider must inform the serious incident to other regulatory, statutory and advisory bodies, such as CQC, NHSE if appropriate without delay.

Wolverhampton CCG requires all providers to notify anyone who has been subject (or someone lawfully acting on their behalf, such as families and carers) to a 'notifiable incident' i.e. incident involving moderate or severe harm or death. This notification must include an appropriate apology and information relating to the incident as per regulation 20: duty of candour guidelines.

The 2015/16 Never Events List (NHS England 2015/2016) details 14 categories of Never Event. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. WCCG takes these

extremely seriously and ensures that contractual sanctions are applied should they occur.

Wolverhampton CCG supports the need to take a whole system approach to quality improvement, and will build on the fundamental purpose of patient safety investigation, which is to learn from incidents and not to apportion blame. The CCG continues to endorse the application of the recognised system-based method for conducting investigations – Root Cause Analysis (RCA) and its mechanism for driving improvement.

Providers hold responsibility for the safety of their patients, visitors and any others using their services. They must ensure that robust systems are in place for recognising, reporting, investigating and responding to serious incidents and for arranging and resourcing investigations.

Wolverhampton CCG Quality Nurse Advisor team provides support to Care Homes with the RCA process for serious incidents that occur within Care Homes, however the CCG are providing training for care home managers in order to improve their skills to complete the RCA process independently and more effectively.

The serious incident status for providers, commissioned services and the CCG are reported on a monthly basis to the Quality and Safety Committee, and lessons learned from serious incidents are reported on a quarterly basis. This information is used to provide intelligence for triangulation with other key performance indicators and any other areas of concern.

For services where Wolverhampton CCG is not the lead commissioner, we work with the lead commissioner to ensure that we are informed of incidents that affect our population.

Once RCA investigations are complete and submitted to the CCG for closure, WCCG holds a bi weekly Serious Incident Scrutiny Group. Recently, the SISG panel has invited providers to attend the SISG (Serious Incidents Scrutiny Group) to ensure an effective and a collaborative approach to scrutinising these SI's and to ensure that they are closed within recommended timeframes. There may be different outcome to the serious incidents presented to the SISG panel and it will depend on the nature of the incident, level of scrutiny and level of assurance provided to the WCCG through the RCA/Action plan etc. Any serious incidents not meeting these thresholds or lacking assurance will be deferred back to the provider.

All investigation reports are reviewed within this group and scrutinised prior to closure, ensuring that robust action plans are in place and all appropriate measures have been implemented to ensure that lessons learned are embedded in practice. Closure of an incident marks the completion of the investigation process only. It is possible to close incidents before all preventative actions have been implemented and reviewed for efficacy, particularly if actions are continuous or long term. Wolverhampton CCG ensures that mechanisms are in place for monitoring implementation of long term/on-going actions.

All of the above operates within NHS England's Serious Incident Framework – supporting learning to prevent recurrence (2015). Investigations within this framework are conducted for the purposes of learning to prevent reoccurrence. They are not inquiries into how a person died as this is a matter for the Coroner to determine. Neither are they conducted to hold any



individual or organisation to account – other processes exist for that purpose including:

- Criminal or civil proceedings
- Disciplinary procedures
- Employment law
- Systems of service and professional regulation – the Care Quality Commission, Nursing and Midwifery Council, Health and Care Professions Council and the General Medical Council

In circumstances where the actions of other agencies are required, WCCG will inform the relevant agencies.

Wolverhampton CCG aims to facilitate learning by promoting a fair, open and just culture, with robust application of duty of candour. The obligations associated with the statutory duty of candour are contained in regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

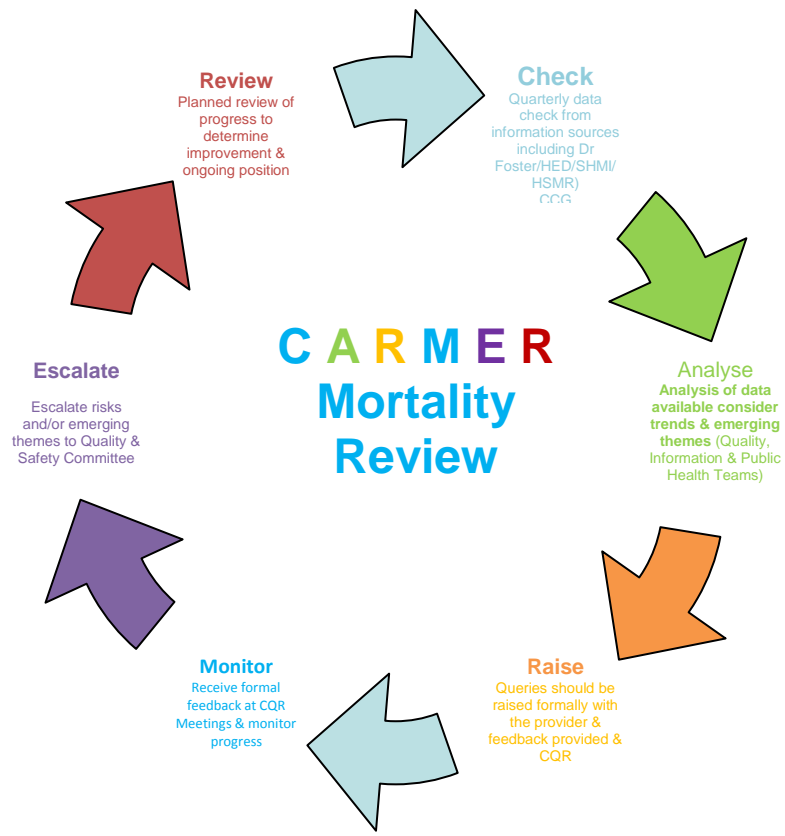
### Mortality

A multi-agency approach to monitoring and reviewing mortality has been a key area of quality monitoring undertaken through triangulation of a range of information sources available to Public Health, Providers and the CCG. Consideration is given to the causal factors where greater prevalence is observed and may be above tolerance when benchmarked with other data sources including CQC, NHS England etc.

A locally developed model has been used to facilitate this work, the CARMER Mortality Review Process below demonstrates how inter-agency consideration of mortality information will be undertaken:-

<b>CHECK</b>	At quarterly intervals check information available from a range of sources including Dr Foster, HED, SMHI, HSMR, Public Health & MORAG to enable triangulation of intelligence.
<b>ANALYSE</b>	Analyse information available to consider trends & emerging themes & possible alerts on influencing factors/cause of death across the health economy. Stakeholders involved in quarterly checks include CCG, Public Health & CSU.
<b>RAISE</b>	Queries/outcomes from analysis of mortality data should be raised with the provider(s) and fed back to CMOG members and be included in the next Clinical Quality Review Meeting (mortality theme).
<b>MONITOR</b>	Receive formal feedback at respective Clinical Quality Review Meeting(s) following queries raised with providers following quarterly CMOG Meetings and continue to monitor progress.
<b>ESCALATE</b>	Risks and/or emerging themes should be not only raised with the provider(s) but also escalated to Quality & Safety Committee in order for them to be a) aware and b) kept informed and c) recorded on the CCG Risk Register, when deemed appropriate.
<b>REVIEW</b>	Planned routine review of progress should take place at CMOG as part of the agenda setting process to determine whether sufficient assurance has been proven to determine improvement or further deterioration.

Correlation with information provided by the Royal Wolverhampton Trust should coincide with other data sources reported upon by Public Health and the CCG to enable queries and ambiguities to be raised with the trust either at MORAG and/or CQR.



The Clinical Quality Review meeting(s) (Black Country Partnership and Royal Wolverhampton Trust) receive regular reports on mortality (quarterly intervals) initiated by the trusts Mortality Oversight Review & Assurance Group (MORAG). Mortality rates are considered to determine whether they are improving or deteriorating and assurance of mitigating actions being taken by the trust. The CCG routinely receive documentation and hold formal membership of MORAG, this is achieved via attendance of a CCG Board Member (Accountable Officer, Quality Lead or similar). Cross fertilisation of information between MORAG, CQR and Commissioner Mortality Oversight Group is undertaken at quarterly intervals providing assurance and risk information to the CCG Quality and Safety Committee and Local Authority Health and Wellbeing Board.

### Infection Prevention

Reducing Health Care Associated Infections (HCAI's) remains high on the Governments safety and quality agenda and in the general public's expectations for quality of care. Antimicrobial resistance (AMR) concerns the entire world and requires action at local, national and global level. AMR cannot be eradicated, but a multi-disciplinary approach involving a wide range of partners will limit the risk of AMR and minimise its impact for health, now and in the future (DOH 2013).

To slow down the development of antibiotic resistance, it is important to use antibiotics in the right way – to use the right drug, at the right dose, at the right time, for the right duration. Therefore the CCG is working with our local partners where the aims are to:

- Reduced public expectation about receiving antibiotics
- Improved understanding of when antibiotics should and shouldn't be used
- Improved understanding of AMR
- Increase the local number of registered Antibiotic Guardians
- Targeting antibiotic therapy in the hospital
- Implementing a structured antimicrobial stewardship plans in the hospital
- Reviewing local surveillance and assessing microbiological data
- Implementing a quality prescribing scheme to enable antibiotic stewardship for prescribers working in primary care.

Quantifiable measurements are used to reflect the critical success of provider(s) with indicators and a target or plan. The quality requirements defined within our service specification serves as a benchmark improvement. The indicators facilitate Wolverhampton CCG to understand, compare, predict outcomes and improve care.

In achieving a reduction in the burden of Health Care Associated Infections, in particular Meticillin-Resistant Staphylococcus Aureus (MRSA) and C Difficile the CCG works collaboratively with their service provider and Public Health using training, audits and implementation of best practice from root cause analysis and also affords access to specialist advice and support. A key area of importance is to reduce the spread of infection and outbreaks not only in hospital but community care settings also.

Infection prevention and control is fundamental in improving the safety and quality of care provided to patients. Reducing Healthcare associated infections is high on the quality and safety agenda for the CCG. The aim is to prevent infections through provision of comprehensive, high quality and evidence based infection control support. Therefore the focus skill will be to reduce and sustain reductions in health care associated infections.

Through collaboration with the Royal Wolverhampton Trust there is a citywide improvement plan in place to combat the problems experienced across the city with infection prevention. Monitoring and review of the work plan is undertaken in conjunction with Public Health and reported to the responsible committee at quarterly intervals. A copy of the service specification will provide fuller detail on the provision of service.

WCCG supports local and national Infection Prevention Strategies, the overall aim being to deliver harm free care for those accessing health care in Wolverhampton. It is aimed at supporting 3 domains of the NHS outcomes framework:

- Preventing people from dying prematurely
- Ensuring that people have a positive experience of healthcare
- Treating and caring for people in a safe environment and protecting them from avoidable harm and should include reduction of Pressure Injuries, CDiff and MRSA.

The CCG has refreshed the Service Specification for Infection prevention, with particular

reference to specific gold standard IP indicators, adapted from the Infection Prevention and control commissioning toolkit (Infection Prevention Society and the Royal College of Nursing). This makes reference to UK's 5 year antimicrobial resistance strategy 2013 – 2018 (DOH 2013) and supports local and national Infection Prevention Strategies, the overall aim being to deliver harm free care for those accessing health care in Wolverhampton. It is aimed at supporting 3 domains of the NHS outcomes framework:

The Quality requirements within the Service Specification acknowledge the ambition to strive for 100 per cent compliance with the indicators. The aim of the infection prevention and control service is to prevent infections through provision of comprehensive high quality evidence-based infection control support. The focus of the service will be to reduce and sustain reductions in healthcare-associated infections. In particular, the service will aim to achieve a reduction in the rate of C Difficile infections, in line with national objectives and support the CCG to deliver on the requirement for zero tolerance of avoidable MRSA bacteremia.

## Safeguarding – Children

The Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework 2015 was commissioned in order to set out clearly the responsibilities of each of the key players for safeguarding in the future NHS. The framework is intended to support NHS organisations in order to fulfil their statutory safeguarding duties as set out in;

- Working Together to Safeguard Children (2015)
- Statutory Guidance on Promoting the Health and Wellbeing of Looked After Children (2015)

CCGs are statutorily responsible for ensuring that the organisation from which they commission services provide a safe system that safeguards children at risk of abuse or neglect. This includes specific responsibilities for Looked after Children and for supporting the Child Death Overview process, to include sudden unexpected deaths in childhood.

CCGs have a statutory duty to be members of the Local Safeguarding Children Board (LSCB) and the Corporate Parenting Board, working in partnership with local authorities to fulfil their safeguarding responsibilities.

CCGs should ensure that robust processes are in place to learn lessons from cases where children die or are seriously harmed and abuse or neglect is suspected. This will include contributing fully to Serious Case Reviews (SCRs) which are commissioned by the LSCB and also where appropriate, conducting individual management reviews.

Health providers are required to demonstrate that they have effective leadership and commitment at all levels of their organisation and that they are fully engaged and in support of local accountability and assurance structures, in particular via the LSCB and their commissioners.

All health providers are required to have safe and effective arrangements in place to safeguard

vulnerable children and to assure commissioners that these are working. These arrangements include, safe recruitments, effective training of all staff, effective supervision arrangements, working in partnership with other agencies, and identification of a Named Nurse, Named Doctor (and a Named Midwife if the organisation provides maternity services) for both safeguarding and LAC.

CCG works with and ensures that all GP practices have a lead for safeguarding, who should work closely with named and designated safeguarding professionals.

Wolverhampton CCG Safeguarding and Looked after Children Team will continue to monitor WCCG compliance regarding its responsibilities for safeguarding and Looked after Children through regular self – assessments and implementation of action plans to address areas for development.

Wolverhampton CCG Safeguarding Team and Looked after Children Team will monitor that health providers have effective arrangements in place to safeguard vulnerable children through the development of effective professional relationships with the safeguarding and LAC leads in provider organisations to foster an open and transparent reporting framework in order to provide commissioners assurance at the appropriate forums and effective professional challenge as appropriate.

Wolverhampton CCG Safeguarding Children and Looked after Children Team will further develop processes to disseminate lessons learnt from the full range of reviews carried out by Wolverhampton Safeguarding Children Board to services commissioned by Wolverhampton CCG, and to monitor the implementation of the recommendations and the embedding of these into practice.

Wolverhampton CCG will continue to ensure appropriate representation is made at Safeguarding forums – including WSCB, Corporate Parenting Board and provider forums.

The designated professionals will continue to offer support and supervision for the named professionals in provider organisations and to work with the Named GP Safeguarding Children to support GPs and their staff to fulfil their roles and responsibilities to safeguard children.

## **Safeguarding – Adults**

Safeguarding means protecting a person’s right to live in safety, free from abuse and neglect. As commissioners, WCCG must demonstrate the aims of adult safeguarding:

- To prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- To safeguard individuals in a way that supports them in making choices and having control in how they choose to live their lives
- To promote an outcomes approach in safeguarding that works for people resulting in the best experience possible
- To raise public awareness so that professionals, other staff and communities as a whole play their part in preventing, identifying and responding to abuse and neglect

There are fundamental requirements for effective safeguarding in the delivery of NHS care:

- NHS Wolverhampton Clinical Commissioning Group has responsibility to assure the quality and safety of the organisations with which contracts are held, and ensure that those contracts have explicit clauses that hold the providers to account for preventing and dealing promptly and appropriately with any example of abuse and neglect. The 2017/18 safeguarding contract information requirements have been strengthened to include a safeguarding dashboard and the requirement for providers to complete a quarterly and annual assurance report using a generic template developed by the WCCG Safeguarding Team
- To prevent safeguarding incidents arising through the provision of high quality NHS care. This includes the NHS Outcomes Framework which sets out the high-level national outcomes that the NHS should be aiming to improve
- Treating and caring for people in a safe environment; and protecting them from avoidable harm.
- To ensure effective responses where harm or abuse occurs through multi-agency adult safeguarding policies and procedures.

WCCG has worked in collaboration with City of Wolverhampton Council to ensure that the Safeguarding elements of the Care Act 2014 are implemented and have also supported the development of the Adult Multi Agency Safeguarding Hub.

The Care Act (2014) represents a landmark piece of legislation to modernise and consolidate social care law (which is based on thirty Acts including the 1948 National Assistance Act). It is the most significant piece of legislation in our sector since the establishment of the welfare state.

Underlining the reforms is a vision of a more integrated approach to the design and delivery of social, housing and health care services. The Better Care Fund is a vehicle for this. It is essential that there is clarity about responsibilities in relation to safeguarding within these new arrangements and how the new system can help drive continued improvement in practice and outcomes.

Adult Safeguarding is the process of protecting adults with care and support needs from abuse or neglect. It is an integral part of what many public services do, but the key responsibility is with local authorities in partnership with the police and the NHS.

From April 2015 each local authority must:

- Make enquiries, or ensure others to do so, if it believes an adult is subject to, or at risk of abuse or neglect. An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so by whom
- Set up a Safeguarding Adults Board (SAB) with core membership from the local authority, the Police and the NHS (specifically the Clinical Commissioning Group/s) and

the power to include other relevant bodies. Wolverhampton CCG will be represented on the Safeguarding Adult Board by the Executive Director of Nursing and Quality

- Arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate adult to help them
- Cooperate with each of its relevant partners in order to protect adults experiencing or at risk of abuse or neglect

WCCG has the appropriate systems in place to manage requests for contributions towards Section 42 Enquiries and other safeguarding quality issues raised for WCCG's attention. The CCG's Joint Children and Adults Safeguarding Policy (2017) and the WCCG Safeguarding Strategy (reviewed 2017) will need to be read with reference to other CCG policies as indicated within the policy and:

- Adult Safeguarding: Multi- Agency policy and procedures for the protection of adults with care and support needs in the West Midlands (2016)
- NHS England – Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework (2015)
- Wolverhampton City Council's Local Practice Guidance

WCCG is represented on the following by the Designated Adult Safeguarding Lead:

- Wolverhampton Safeguarding Adults Board
- Safeguarding Adults Review Committee
- Learning and Development Committee
- Quality and Performance Committee
- Domestic Homicide Review Standing Panel

Prevent: Wolverhampton CCG is a commissioning organisation and as such will have limited contact with members of the public or patients. There are, however, a number of potential interactions between the organisation and the public that could result in concerns being identified regarding the radicalisation of individuals. Radicalisation is a process by which an individual or group comes to adopt increasingly extreme political, social, or religious ideals and aspirations that reject or undermine the status quo.

The CCG also has a role to oversee how the organisations from which it commissions services are complying with the requirements of the National NHS Contract and the National Prevent Strategy. The CCG will also support and promote a Wolverhampton wide approach to Prevent, ensuring that there is one standard approach to information, awareness, training, and reaction/escalation to concerns.

WCCG will ensure that it is represented appropriately, and work collaboratively, in local Prevent partnership work including:

- Channel panel
- Wolverhampton CONTEST Steering Group
- Safer Wolverhampton Partnership

The CCG's Prevent Policy and Referral process (2016) should be referred to for further information and referral processes.

Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLs) – WCCG continue to support a project hosted by Walsall CCG (provided by Dudley and Walsall Mental Health Trust) which has raised awareness and provided training across the Black Country. Valuable resources have been developed; including scenario based video's which can be accessed via Dudley CCG's website.

### NICE Assurance

There is a systematic process in place for planning, implementing, auditing and evaluating NICE guidance in the services it commissions. It accepts that NICE guidance is evidence based and represents good practice and effective use of resources.

There is an obligation to implement Technical Appraisal Guidance and consider NICE guidance issued by National Institute for Health and Care Excellence (NICE), which is the independent organisation responsible for providing national guidance and quality standards on the promotion of good health and the prevention and treatment of ill health.

NICE guidance is based upon the best available clinical evidence on what works and is cost effective evidence. There is an expectation that health professionals will take national guidance fully into account as part of their clinical practice, it is intended to support clinician's skill and knowledge.

WCCG has a responsibility for commissioning and delivering services that are compliant with NICE guidance and NICE Quality Standards in order to:

- ensure patients and service users receive the best and most appropriate treatment
- ensure the NHS resources are used to provide the most clinically and cost effective treatment
- ensure equity through consistent application of NICE guidance

Adherence to the policy will provide assurance that WCCG fulfils its responsibility to implement best practice as a matter of course and that it is working in partnership with other organisations. The principles to provide a systematic and transparent approach are:-

- Horizon scanning and forward planning
- Identification of clinical leads and service areas for dissemination
- Monitoring of local assessment and uptake
- Maintenance of WCCG data base to record actions



There are duties placed upon commissioners and providers of services, the policy defines the practical steps that should be taken to ensure treatment and practice are changed in light of new and emerging quality standards, guidance and technical appraisals. In order to obtain assurance the CCGs NICE Assurance Group (NAG) meets regularly to review progress and status with each of its commissioned providers and works closely with stakeholders including Public Health and Primary Care to enable an integrated approach to quality and care delivery.

### Commissioning Quality and Innovation (CQUINs)

NHS England this year introduced a number of changes to the CQUIN scheme which were first introduced in 2009. All CQUINs for 2017-19 are nationally mandated and will be looking harder at each provider type, and designed schemes for specific provider settings. The selection of CQUIN's for 2017-19 for our providers will fully support our strategic priorities to deliver quality and innovation. The quality team will work collaboratively to develop and monitor provider CQUINS.

The value of the CQUIN scheme will be 2.5% of Actual Contract Value as defined in the NHS Standard Contract. The percentage value earned will be dependent on provider performance.

Providers with agreed CQUINs in their contract will submit data to support performance on a monthly/quarterly basis which is then reviewed and challenged by the lead Quality Assurance Coordinator for that contract. Quarterly reconciliation meetings are held between the CCG and the provider to agree performance and identify any areas where CQUIN monies may be withheld due to performance issues. The quarterly performance is reported through the relevant CQRM and also to the Quality and Safety Committee via the Quality Report.

Commissioners may, in addition to CQUINs, offer additional incentives to providers and these are recorded as Local Incentive Schemes in the relevant schedule of the NHS Contract.

We are responsible for the following:

- Monitoring delivery of standards and quality through the commissioning process
- A duty to require and monitor delivery of fundamental standards
- Ensuring there are resources to enable proper scrutiny of our providers' services, based on sound commissioning contracts
- Ensuring assessment and enforcement of fundamental standards through contracts and the development of alternative sources of provision if necessary.

Our CQUIN selection for our main Acute and Mental Health providers for 2017-19 are:

<b>Acute Provider</b>	<b>Mental Health Provider</b>
NHS Staff Health and Wellbeing	NHS Staff Health and Wellbeing
Reducing the impact of serious infections	Child and young person Mental Health transition
E-referrals	Physical health for people with severe

	mental illness
Supporting proactive and safe discharge	Improving services for people with Mental Health needs who present to A/E
Improving the assessment of wound	Preventing ill health by risky behaviours –alcohol and tobacco
Personalised care planning	

### Clinical Quality Review Meetings

Clinical Quality Review meetings will be maintained for all of our main providers of service. The lead commissioner takes responsibility for the management of these meetings. The frequency of these meetings will be at no longer than quarterly intervals for larger providers and no longer than annual intervals for smaller providers.

A collaborative approach to monitoring the quality of care provided by smaller providers who are commissioned by multiple associates is actively encouraged.

Terms of reference for all Quality Review Meetings and Quality and Safety Committee Meetings are routinely reviewed at no longer than 6 month intervals to ensure they are an accurate reflection of the responsibilities of the both forums.

Meeting schedules will be shared with members to enable efficiency and timely information distribution of a draft agenda issued 2 weeks prior, comments/papers received and distributed 1 week prior to the meeting and minutes issued 7-10 days later.

All Clinical Quality Review meetings will be chaired by a CCG Board Member wherever possible and supported by the Quality and Risk Team with attendance at senior office level from provider organisations.

In accordance with NHS National Contract clauses, the Clinical Quality Review meetings will be managed in accordance with clinical quality review and quality requirements focusing on the providers clinical quality performance report (monthly), progress made against CQUINs and Key Performance Indicators (KPI's) etc.

### Quality Matters

Quality Matters launched in March 2012 and is a facility available to GPs, Contracted Providers and Associate Commissioners to enable concerns or requirements associated with an experience of a healthcare organisation and the impact on the quality of care received by the patient(s). There have been almost 1150 raised to date (March 2012 - March 2017).

The CCG Quality team currently receives and responds to traffic from one provider & another via the Quality Matters Communication Process. In the first instance the initial source will send a quality concern through the designated email address, where a member of the Quality Team checks emails on a daily basis. The concern(s) are then acknowledged and prioritised accordingly. Issues are evaluated and either escalated or a conclusion fed back immediately.

A response date is allocated to an individual concern and is identified by the severity of the concern raised.

Once the issue has been resolved, information is fed back to the initial source, the concern is then either closed, or the source replies with additional details that need discussion. Findings from all Quality Matters are reported on a monthly basis to relevant committees. Actions taken include changes to processes, pathways and working arrangements across all providers. The system is well used by both GPs and providers from Wolverhampton and other areas beyond the CCG boundaries.

## Quality Governance

The Quality and Safety Committee, a subcommittee of the CCG Governing Body, will be responsible for receiving assurance that commissioned services are being delivered in a high quality and safe manner, ensuring that quality sits at the heart of everything the clinical commissioning group does. This will include jointly commissioned services and supporting NHS England as regards the quality and safety of the healthcare services that it commissions on behalf of the local population.

## Assurance Reporting

A range of reports are produced routinely and in response to specific requirements by the Quality and Risk Team that are considered by the Quality and Safety Committee and where necessary other groups/forums either within or sometimes outside of the CCG.

Quality Assurance is routinely reported at an aggregated level each month to the Quality and Safety Committee and subject to scrutiny where deemed appropriate by members in line with the committee's terms of reference.

Each of the forums within the Quality Framework will receive and consider reports and information pertaining to the expanse of quality monitoring that takes place. The following forums will consider and receive such information and take decisions on whether they accept or require further detail to support a particular area of importance:-

- Quality and Safety Committee
- Clinical Quality Review Meetings
- Commissioner Mortality Oversight Group
- NICE Assurance Group
- Serious Incident Scrutiny Group
- Primary Care

There are also exception reports generated on a weekly basis that confirm the CCGs position regarding new serious incidents, number open, number overdue and an overview of concerns across the cities care homes. The report provides a quick snapshot of activity and issues to be aware of over the past week.

In addition the CCG has a well-developed and embedded Quality and Safety Trigger and Escalation Model, previously mentioned in this document and will be used to communicate rising concerns with the Medical or Nursing Directors of the provider organisations. This is a formal, written process which requires an urgent investigation and response from the Directors. These are monitored at CQRM.

## Equality, Inclusion and Human Rights (EIHR)

### Context

The Equality Act 2010 simplified and harmonised equality law. Importantly, it also strengthens the law to help tackle discrimination and inequality. The Act applies to all employers and service providers in the United Kingdom.

The Act also introduces a new specific Public Sector Equality Duty (PSED), which means all public authorities must demonstrate proactive 'due regard' to:

- **eliminate** unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act;
- **advance** equality of opportunity between people who share a protected characteristic and those who do not;
- **foster** good relations between people who share a protected characteristic and those who do not;
- (s149, Equality Act 2010)
- There are Specific Duties which require organisations to:
- **promote transparency** – public bodies are required to publish service delivery information to show compliance, and those that employ more than 150 staff, must also publish workforce profile information, at least annually in an accessible way;
- **setting equality objectives** – public bodies are required to set their own equality objectives based on evidence and data, at least every four years as part of their strategy and be able to measure their success against their equality objectives;

The Equality Act 2010 provides protection to the following groups of people based on the protected characteristics listed below:

- age
- disability
- gender reassignment
- marriage and civil partnership – only in respect of eliminating unlawful discrimination
- pregnancy and maternity
- race – this includes ethnic or national origin, colour or nationality
- religion and belief
- sex
- sexual orientation

## Equality, Inclusion, and Human Rights

### What are Equality, Inclusion and Human Rights (EIHR)?

**Equality** is about creating a fairer society where everyone can participate and have the opportunity to fulfil their potential; it is not about treating everyone the same. It is backed by legislation designed to address unfair discrimination based on particular protected characteristics.

Equality and Diversity are not inter-changeable but inter-dependent. There can be no equality of opportunity if difference is not valued and harnessed and taken into account.

**Inclusion** is about the combination of diversity and a positive vigour and striving to meet the needs of different people by creating an environment where everyone feels respected, properly involve and empower by creating the right environment to enable all to realise and their full potential. There is recognition that some individuals and groups, for a variety of differences and reasons, find it more difficult to have their voice heard in mainstream society.

**Human rights** are the basic rights and freedoms that belong to every person. They are the fundamental things that human beings need in order to flourish and participate fully in society. Human rights belong to everyone, regardless of their circumstances. They cannot be given or taken away – although some rights can be limited or restricted in certain circumstances. For example, your right to liberty (Article 5, Human Rights Act 1998) can be restricted if you are convicted of a crime, or subject to section under the Mental Health Act.

Having ‘due regard’ means consciously thinking about the three aims of the Equality Duty:

- **removing or minimising disadvantages** suffered by people due to their protected characteristic;
- **taking steps to meet the needs of people** from protected groups where these are different from the needs of other people;
- **encouraging people from protected groups** to participate in public life or in other activities where their participation is disproportionately low

Equality Analysis (EAs) is a process enabling managers to address fundamental questions in considering and understanding how a proposal for healthcare changes, can help them to meet all service users requirements including ensuring quality. It specifically seeks to address the following issues:

- Is there any direct discrimination?
- Is there any potential for indirect discrimination?
- What engagement and involvement has been carried out and who with?
- What was the outcome of any engagement and involvement? And how has this informed the decisions made?
- Is any group disproportionately affected?
- What are the potential adverse impacts?
- What actions will be taken to mitigate any adverse impact?
- Positive impact to be highlighted

The aforementioned considerations should also be considered during any quality and risk activities, paying specific attention to people from any protected characteristic as detailed within the Equality Act 2010.

The NHS has designed a reporting framework for all healthcare organisations to use to demonstrate progress in equality, inclusion and human rights area.

The main purpose of the Equality Delivery System<sup>2</sup> (EDS2) is to help local NHS organisations, in discussion with local partners including local stakeholders, review and improve their performance for people with characteristics protected by the Equality Act 2010. There are key elements and outcomes of the EDS2 that are intrinsic with aspects of clinical quality.

## **The interface between the Quality Strategy and Equality, Diversity, Inclusion and Human Rights (EIHR)**

### **The Golden Thread**

To summarise, Clinical Quality prioritises assurance of quality of care for all patients regardless of their background or circumstance. A number of operational strategies are deployed to understand all patient needs, for example listening to patient feedback and experience and acting upon that feedback, as well as ensuring that patients' NHS Constitution rights are delivered and upheld.

EIHR prioritises the understanding of the diverse communities being served, dealing with principles of fairness, respect and dignity. The NHS Constitution details a duty to protect and promote equality, inclusion and human rights for everyone. Clinical quality and EIHR are interdependent to enable service to be safe and effective for sections of the community. There is a co-dependent relationship between Quality Impact Assessments and EAs in respect of all the principles mentioned.

The interface between clinical quality and EIHR, demonstrates the CCG's commitment towards dealing fairly and equitably with issues of equality as part of the quality and risk function.

Key points are:

- the importance of ensuring that all patients receive a safe high quality and equitable service regardless of age, sex, race, disability, sexual orientation, gender reassignment, religion and belief or any other personal characteristic;
- the importance to embed equality and human rights considerations as part of all quality and risk functions/activities;
- the opportunity to improve health outcomes and reduce health inequalities;
- meeting patients cultural and religious needs;
- the importance of embedding the NHS Equality Delivery System and the Workforce Race Equality Standards (where relevant), in core activities;
- carrying out EAs to demonstrate and evidence 'due regard' and from a potential and risk perspective, clinical quality and EA's are closely related and must be linked together.

## Risk Management

The Quality Strategy is closely aligned with the CCGs Risk Management Strategy through applying equally as much rigour to the application of risk management to care quality therefore ensuring that risks are identified, recorded and duly reported. Within the scope of the risk management system care quality features strongly and is treated with all seriousness to ensure that robust mitigating actions have been identified and indeed implemented to reduce risks to patients and the services they access.

Risk Management is a key feature in the monthly assurance reports presented to the Quality & Safety Committee, also shared with Senior Management Team Meetings periodically and subject to scrutiny and oversight by a responsible director for each risk that enables ownership and furtherance of risk recording and scoring. Particular attention is paid to red risks to ensure that all reasonable action is being taken to reduce the likelihood of patients receiving care being unsafe, having a negative experience of care or care that is ineffective.

## Annual Quality Report

We will produce an Annual Quality Report to provide an overview of both quality performance within the CCG during the year and the quality performance of provider organisations from which healthcare is purchased, together with details of any action taken to address identified quality related issues. Our priorities for the following year will also be set out within the report.

We will publish our Annual Quality Report on the CCG's website.

## Summary

The CCG has a strong and effective quality function which works collaboratively with its providers and other organisations to deliver high quality services to the residents of Wolverhampton for whom it commissions health care.

Our Quality Strategy builds on these existing strengths and sets out our approach to quality over the next three years. It includes details of our specific objectives and planned programmes of work which support the CCG's overarching Strategy and will assist us to deliver our overall aim of improving individuals' quality of life and their experience of health care by commissioning high quality accessible services that reflect their needs.



## SIGN UP PACK (V1.5 Updated November 16)

### Welcome to Sign up to Safety

#### Listen, Learn, Act

**Listening** to patients, carers and staff, **learning** from what they say when things go wrong and take **action** to improve patients' safety.

Our vision is for the whole NHS to become the safest healthcare system in the world, aiming to deliver harm free care for every patient every time. This means taking all the activities and programmes that each of our organisations undertake and aligning them with this single common purpose.

Sign up to Safety has an ambition of halving avoidable harm in the NHS over the next three years and saving 6,000 lives as a result.

As Chief Executive or leader of your organisation, we invite you sign up to the campaign by setting out what your organisation will do to deliver safer care

- Describing the actions your organisation will undertake in response to the five Sign up to Safety pledges (see page 3 to 5) and agree to publish this on your organisation's website for staff, patients and the public to see. You may like to share and compare your ideas before you publish – this support will be available to you.
- Committing to turn your proposed actions into a **Safety Improvement Plan** which will show how your organisation intends to save lives and reduce harm for patients over the next 3 years. Again, support will be available, if you wish to access it, to assist in the description of these plans.
- Within your Safety Improvement Plan you will be asked to identify the patient safety improvement areas you will focus on.

To officially sign up your organisation to the campaign, please complete the following sign up form and return via email to [england.signuptosafety@nhs.net](mailto:england.signuptosafety@nhs.net)



# Sign up to SAFETY

## LISTEN LEARN ACT SIGN UP FORM


Organisation name: **Wolverhampton CCG**

In signing up, we commit to strengthening our patient safety by:

- Describing the actions (on the following pages) we will undertake in response to the five campaign pledges
- Committing to turn these actions into a Safety Improvement Plan which will show how our organisation intends to save lives and reduce harm for patients over the next three years.
- Identify the patient safety improvement areas we will focus on within the safety plans.
- Engage our local community, patients and staff to ensure that the focus of our plan reflects what is important to our community
- Make public our plan and update regularly on our progress against it.

Chief Executive or organisation leadership sponsor:

**Helen Hibbs**

Name	Signature	Date
Dr Helen Hibbs		15 06 17

Please tell who will be the key contact in your organisation for Sign up to Safety:

Title:	Mr	First name:	Steven	Last name:	Forsyth
Email:	stevenforsyth@nhs.net			Job title:	Head of Quality & Risk



## The five Sign up to Safety pledges

**1. Putting safety first.** Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans

*We will support our acute and mental health trust in reducing the number of avoidable pressures ulcers and falls causing harm through working collaboratively to learn from incidents and prevent recurrences.*

*Through implementation of the Sepsis CQUIN during 2015/16 seek to ensure our patients are treated in accordance with the prescribed pathway to prevent ill health in patients in an acute setting.*

*Prevent avoidable admissions from care homes through initiatives we have in place to provide care in the right place at the right time using our Hospital In-reach Team and other projects that enable care to be provided closer to home.*

*Promote the management long term health conditions in primary care and community setting to prevent admission to hospital.*

*Our pledges are summarised as follows:-*

- *Reduced Harm from Avoidable Falls*
- *Reduced Harm from Avoidable Pressure Ulcers*
- *Reduced Harm through implementation of Sepsis 6*
- *Prevent Avoidable Admissions to Hospital*
- *Management of Long Term Conditions in Primary Care & Community*

**2. Continually learning.** Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are

*We will promote the use of Quality Matters to share information and learn from feedback shared via primary care and/or our providers so that we are able to strive to continuously improve patient safety, patient experience and clinical effectiveness.*

Sign up to  
.....  
**SAFETY**  
**LISTEN LEARN ACT**

**3. Being honest.** Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong

*We will be open and honest with our patient groups and the public through sharing our trend reports generated through Quality Matters and in response to feedback from patients and the public in line with our Patient Engagement Strategy.*

**4. Collaborating.** Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use

*We will work with Healthwatch, providers and the Local Authority to ensure that so far as is reasonably practical we identify trends, identify learning opportunities and take action to prevent recurring themes continuing in the future.*

**5. Being supportive.** Help our people understand why things go wrong and how to put them right. Give them the time and support to improve and celebrate progress

*We will strengthen information sharing with member practices to enable quality improvement and work to respond to the findings of the GP patient survey, patient surveys in hospital settings and in response to feedback from our Patient Participation Groups.*

## Glossary of Abbreviations

<b>ACP</b>	Advanced Care Plan
<b>AMR</b>	Antimicrobial Resistance
<b>ANP's</b>	Advanced Nurse Practitioners
<b>CCG</b>	Clinical Commissioning Group
<b>CQC</b>	Care Quality Commission
<b>CQR</b>	Contract Quality Review
<b>CQRM</b>	Clinical Quality Review Meeting
<b>CQUIN</b>	Commissioning For Quality And Innovation
<b>CSU</b>	Commissioning Support Unit
<b>DoLs</b>	Deprivation of Liberty Safeguards
<b>EA's</b>	Equality Analysis
<b>EDS2</b>	Equality Delivery System2
<b>EIHR</b>	Equality Diversity Inclusion & Human Rights
<b>EoLC</b>	End of Life Care
<b>GP</b>	General Practitioner
<b>GPFV</b>	General Practice Forward View
<b>GPN</b>	General Practice Nurse
<b>HEE</b>	Health Education England
<b>HEWM</b>	Health Education West Midlands
<b>HSJ</b>	Health Service Journal
<b>KPI</b>	Key Performance Indicator
<b>LA</b>	Local Authority
<b>LAC</b>	Looked after Children
<b>LMC</b>	Local Medical Committees
<b>LSCB</b>	Local Safeguarding Children Board
<b>MASH</b>	Multi Agency Safeguarding Hub
<b>MCA</b>	Mental Capacity Act
<b>MORAG</b>	Mortality Oversight Review Assurance Group
<b>MPCNF</b>	Macmillan Primary Care Nurse Facilitator
<b>NAG</b>	NICE Assurance Group
<b>NHSE</b>	NHS England
<b>NICE</b>	National Institute for Healthcare Excellence
<b>PCC</b>	Primary Care Commissioning
<b>PH</b>	Public Health
<b>QIPP</b>	Quality, Innovation, Productivity and Prevention
<b>QNA</b>	Quality Nurse Advisors
<b>RCA</b>	Root Cause Analysis
<b>RWT</b>	Royal Wolverhampton Trust
<b>SAB</b>	Safeguarding Adults Board

<b>SAR</b>	Safeguarding Adult Review
<b>SCR</b>	Serious Case Review
<b>SI('s)</b>	Serious Incidents
<b>SISG</b>	Serious Incidents Scrutiny Group
<b>SPACE</b>	Safer Provision and Care Excellence
<b>STP</b>	Sustainability Transformation Plan
<b>WCCG</b>	Wolverhampton Clinical Commissioning Group
<b>WRES</b>	Workforce Race Equality Standard

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**Black Country and West Birmingham Joint Committee**

**Minutes of Meeting dated 20 April 2017**

**In attendance:**

David Hegarty – Chairman, Dudley CCG - Chair  
Helen Hibbs – Accountable Officer, Wolverhampton CCG  
Paul Maubach – Accountable Officer, Walsall & Dudley CCG  
Andy Williams – Accountable Officer, Sandwell & West Birmingham CCG  
Jim Oatridge – Interim Chair, Wolverhampton CCG

**Apologies:**

Nick Harding – Chairman, Sandwell & West Birmingham CCG  
Anand Rischie – Chairman, Walsall CCG

**1. Minutes of the last meeting**

Minutes of the meeting held 23 March 2017 were agreed.

**2. Actions from the last meeting**

See action log for updates.

**3. Reports from the Task & finish group reports**

**3a. Comms and engagement**

**Talent management process**

- All discussed the name of the group, needs to be consistent across all 4 CCGs
- Timeframe isn't clear on the talent management process
- 4 CCG staff events (3 AOs to be at all events) to take place before the talent management process starts
- Equalitive analysis process to be included in the talent management process - HR leads to ensure this happens through HR task and finish group. **Action: HR leads**
- All discussed purdah – Communications task and finish group to keep all updated
- Talent management process to include introductory paper to include current management figures

**3b. Finance task & finish group**

- Paper presented to the Joint Committee for information on the review of the financial sustainability - to be reviewed on 22 June 2017
- All agreed that the finance review should proceed as set out in the paper from the Finance task & finish group

**3c. Systems re-design task & finish group**

- Paul Maubach explained that there are differences of opinion on what should be local and what should be place based for mental health. A specific discussion to take place at the next task and finish group on mental health to rectify significant issues – principals to be used in future discussions

- The task and finish group were asked to look at Dudley's scope of services and amend as necessary ahead of the next task and finish group. Paul to update all at the next Joint Committee and then link through CRG

### 3d. Governance

- All agreed that the Terms of Reference for the Joint Committee are to go to all Black Country CCG Governing Bodies for sign off and that the Clinical Reference Group TOR and task and finish group TORs are to go to the 4 Governing Bodies for information only as subsequent groups of the Joint Committee

### Joint committee TOR

- All agreed on the following new membership to the Joint Committee, two Chief Finance Officers and 2 lay members from across all 4 CCGs
- Lay members chosen for the Committee should be involved in two different remits, one of those remits to include communications and public engagement
  - Dudley or Walsall CCG Chief Finance Officer – Matthew Hartland
  - Sandwell & West Birmingham CCG Chief Finance Officer – James Green
  - Lay member for Finance to be chosen from Wolverhampton CCG. **Action: Jim Oatridge**
  - Lay member for patient and public involvement to be chosen from either Dudley or Walsall CCG. **Action: David Hegarty**
- The following changes were made to the Joint Committee TOR. **Action: Paul Maubach**
  - Section 2.5 - remove term 'clinical' chair
  - Anand Rischie - Vice Chair of the Joint Committee
  - Add to section 7, a lay member to manage the conflicts of interest as an extra paragraph in the TOR - action paul Maubach - add to section 7
  - Quorum - 1 CFO or 1 lay member
  - Add to section 6.2 - to make binding decisions on those matters on behalf of the CCG
- All happy to make recommendation to of the TOR to all Governing Bodies

### Clinical Reference Group TOR

- The following changes were made to the CRG TOR. **Action: Paul Maubach**
  - Provision of evidence to come from the work streams - addition
  - Section 6 – addition – to develop a clinical strategy
  - Section 4 - Quorum to be changed to: Chair or Vice Chair and at least 1 voting member from each of the 4 geographical areas
  - Section 3.1 - Chair of CRG not joint committee
- CRG TOR is subject to sign off of CRG. **Action: David Hegarty.**

### All task and finish group TOR

- Agreed by all, to go to Governing Bodies for information

### 4. Programme manager outline of responsibilities

- The proposed outline of responsibilities for the Programme Manager role were presented to all. The applicant of any band 8 level will continue on their existing job description for a period of 12 months working to the outline of responsibilities



- All agreed for the job advert to go out as soon as possible. **Action: Paul Maubach**
- One issue raised was how you differentiate amongst band 8s if you don't have a job description criteria and the need to effectively accommodate this – **Action: Nick Harding for interview stages**

## 5. Any Other Business

### 5a. Clinical Reference Group

- David Hegarty circulated a paper (Appendix 1)
- David Hegarty explained that the CRG are required to create a clinical strategy, an analysis of the data based on projected needs of populations to align with national 'must do's' (data has to largely come from Rightcare)
- The first iteration of the strategy should be completed by the end of May with then a projected 6 month period to complete.
- Finance task & finish group – look at the methodology by which we share resources - **Action: Andy Williams**
- Recommendation in paper regarding project manager for CRG - strategy unit cover in short term as previously agreed
- All agreed on the proposed costs to the Strategy Unit

### 5b. Key communications from this meeting to HR

- All agreed that as a decision making group, staff and the public should be updated on all decisions made and that the communications task and finish group are to do an interpretation of the minutes. **Action: Helen Hibbs**
- Once meeting minutes are approved, they are to be sent out with the public Governing Body Board papers

Date of next meeting: 25<sup>th</sup> May, 1 – 2.30pm



# Black Country and West Birmingham Joint Committee

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## Minutes of Meeting dated 25 May 2017

### In attendance:

Nick Harding – Chairman, Sandwell & West Birmingham CCG – Chair  
Anand Rischie – Chairman, Walsall CCG  
David Hegarty – Chairman, Dudley CCG  
Helen Hibbs – Accountable Officer, Wolverhampton CCG  
Paul Maubach – Accountable Officer, Dudley CCG & Walsall CCG  
Andy Williams – Accountable Officer, Sandwell & West Birmingham CCG  
Jim Oatridge – Interim Chair, Wolverhampton CCG  
Matthew Hartland – Chief Operating & Finance Officer, Dudley CCG and Interim Strategic Finance Officer, Walsall CCG  
James Green – Chief Finance Officer, Sandwell & West Birmingham CCG  
Simon Collings – Assistant Director of Specialised Commissioning, NHS England  
Claire Finn – Head of Finance, NHS England – Midlands & East  
Clare Hamilton – Executive Assistant to David Hegarty & Paul Maubach, Dudley CCG – Note taker

### Apologies:

Peter Price – Lay member, Wolverhampton CCG

### 1. Minutes of the last meeting

Minutes of the meeting held 20 April 2017 were agreed.

### 2. Actions from the last meeting

See action log for updates.

### 3. STP Update

Andy Williams updated all on the Sustainability & Transformation Plan. Andy, Paul Maubach, David Hegarty, James Green & Helen Hibbs attended the Quarter 1 Stocktake Event with NHS England and NHS Improvement on 25 May 2017. Andy Williams has now been identified as the Black Country STP lead. Positive feedback was received from NHSI and NHSE regarding the Black Country & West Birmingham Joint Committee.

All agreed that a clinical lead and programme management lead will be required for each Black Country service area and each service area will include (but not be limited to) the six priority areas that NHS England have identified. These areas will complement the STP agenda, so some of these leads, as well as being the CCG lead representative, may also become the lead representative for the STP as a whole. Andy Williams to work with HR to standardise a process across all four CCGs to ensure a fair and consistent approach is reached if there is more than one applicant for each future post. **Action: Andy Williams**

Paul Maubach explained that Walsall CCG are currently consulting on moving their Stroke services, however, this is not happening on a Black Country basis. All agreed to adopt a model where there are three approaches to how services are commissioned in the future:

1. Commissioning on a Black Country level (across all four CCGs)
2. Commissioned on place based with Black Country wide pathways of care (each CCG commissions its own model locally, but to the same agreed standards / protocols across all four CCGs with the same contract)
3. Place based commissioning (each CCG has its own model and each has its own contract which may differ from the others)

#### **4. Reports from the Task & Finish group reports**

##### **4a. Governance Task & Finish group**

- Paul Maubach updated all on the above Task & Finish group
- All Task & Finish groups are now taking place monthly
- Joint Committee Terms of Reference has not yet been approved by all Governing Bodies
- A discussion took place regarding Nurse representation on the Joint Committee, all agreed to look at future representation once the Joint Committee has received delegation from all four Governing Bodies
- Each CCG to source a Non-Executive Director to represent on the Joint Committee  
*Action: CCG Chairs*

##### **4b. Systems Re-design Task & Finish group**

- Paul Maubach updated all on the above Task & Finish group
- The group are currently debating their shared scope of services based on Dudley's scope
- All agreed on the proposed principles which will be used to determine which services, for the long-term are to be commissioned on a place based or Black Country level
- All agreed that a shared piece of work is required to define what it means in practice to commission a place based model and for each CCG to share their intelligence around this

##### **4c. Infrastructure Task & Finish group**

- Helen Hibbs updated all on the above Task & Finish group
- Discussions are taking place regarding an estates solution and how this can be determined alongside a Clinical Strategy being defined
- Nick Harding to share details of the national IT lead at NHS England with Helen Hibbs
- All agreed that cyber attack planning should be part of this Task & Finish group

##### **4d. Communications & Engagement Task & Finish group**

- Helen Hibbs updated all on the above Task & Finish group

##### **4e. CCG Collaboration Task & Finish Group**

- Andy Williams updated all on the above Task & Finish group
- Andy described an overlap between System Re-design and Collaborative Commissioning
- All agreed that a workshop should take place with senior commissioners to work on the areas of comparison

- All agreed that this group would concentrate mutually on the six key areas described above
- Matt Hartland updated on progress on 'back office functions' element of the work programme

#### **4f. Finance Task & Finish Group**

- James Green updated all on the above Task & Finish group
- A specification has been drafted for the Black Country wide provider analysis which will be provided soon
- The potential conflict/duplication of MMH reviews was discussed and it was agreed that only one review was required, and Andy Williams to discuss with NHSE whether an extension to the scope is required

*David Hegarty and Matthew Hartland left the meeting.*

#### **5. Specialised Commissioning**

Simon Collings updated all on Specialised Commissioning and will be attending all future Joint Committee meetings as Assistant Director of Specialised Commissioning from NHS England.

Simon explained that Specialised Commissioning will have a 'seat' at all collaborative commissioning arrangement meetings that include place based commissioning by April 2018. Ernest and Young are providing Finance and Governance support.

Updates will be required from the Governance Task & Finish Group and Collaborative Commissioning Task & Finish Group from Specialised Commissioning.

#### **Date of next meeting:**

22<sup>nd</sup> June, 1 – 3pm

